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F 000	INITIAL COMMENTS Surveyor: 21794 This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on September 1, 2009 through September 10, 2009, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 157 residents. The sample size was extended to a total of 34 sampled residents which included 7 closed records. An Immediate Jeopardy situation was identified on 9/1/09 at 10:00 AM , at CFR 483.35(i)(2), Store, prepare, distribute and serve food under sanitary conditions. The Immediate Jeopardy was abated at 2:00 PM on 9/1/09. Please refer to Tag 371. The facility was found in substandard quality of care for non-compliance at 483.13 Resident Behavior and Facility Practices. Please refer to Tags F223 and F226. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	F 000		
F 223 SS=H	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

This REQUIREMENT is not met as evidenced by:
Surveyor: 12211

Based on observation, interview, document review, and record review, the facility failed to ensure that 5 of 34 sampled residents (Resident #10, #13, #22, #25, #29) and 6 unsampled residents (#35, #36, #37, #38, #39, #40) were afforded the right to be free from verbal, sexual, physical and mental abuse.

Findings include:

Note: Individuals identified with brackets [ ] are the offending persons.

Resident #22 [and Unknown Assailant]

Resident #22 was a 54 year old female admitted 8/12/08, with diagnoses including Hypoxemia, Pneumonia, Esophogeal Reflux, Thrombocytopenia, Convulsions, Schizophrenia, Hypothyroidism, and Mental Retardation.

Nurse's Noted dated 10/3/08 1830 (6:30 PM): "Res (resident) was in bed when (unidentified male resident) from the adjacent room came up to her bed and started scratching on the face. Res started screaming and CNA who was doing one-on-one with another res walked into the room to find res bleeding on the face from scratch marks. CNA separated the two res and sought

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help from fellow nsg (nursing) staff who responded promptly. Res appears shaken. Brought to nsg station for evaluation and safety. MD paged for update." (According to the Nurses' Notes, Resident #22 was transferred to Valley Hospital Emergency Room and treated.)

There was no documented evidence the facility submitted a report to the Bureau regarding the 10/3/08 incident. There was no documentation the facility reported the physical abuse to the North Las Vegas Police Department.

Policy Review

The Policy and Procedure (undated) submitted to the Bureau of Health Care Quality and Compliance (Bureau) surveyors on the morning of 9/3/09 included the following:

"TOPIC: PROHIBITING ABUSE
RESPONSIBLE STAFF: All staff, All Departments
REPORTS TO: Administrator, Director of Nursing, and/or Community Coordinators
Purpose: To prohibit abuse of residents from any source. To promote the well-being of residents by providing a safe and supportive environment. To maintain the resident's right to be free from verbal, sexual, physical, mental abuse, corporal punishment and involuntary seclusion.
Definitions:
Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.
Verbal Abuse: The use of oral, written or gestured

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F 223	Continued From page 3 language, that willfully includes disparaging and derogatory terms to residents or their families or within hearing distance, regardless of their age, ability to comprehend, or disability. Sexual Abuse: Including but not limited to sexual harassment, sexual coercion, or sexual assault. Physical Abuse: Hitting, slapping, pinching, kicking, or controlling through corporal punishment. Mental Abuse: Including but not limited to humiliation, harassment, and threats of punishment or deprivation... Neglect: Failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness. Unusual Incident/Accident: An unusual incident and/or injury of unknown origin is used to describe a condition or situation involving a resident which is abnormal or unexpected, and not due to a known disease or known event. Examples of unusual incidents include, but are not limited to, abnormal bruising, scratches, skin alterations, drug abuse, etc. Catastrophic Behaviors: Occurrences of resident to resident abuse or aggression shall be documented on the facility Incident Report form and reported immediately to administration. The interdisciplinary team will be responsible for developing, implementing, and communicating a plan of care with intervention strategies to prevent or manage abusive episodes. Monitoring and reassessment of the resident and the effectiveness of his/her plan of care will occur as per plan of care policy. The Administrator, Director of Nursing or designee will be responsible for maintaining data and reporting pattern and trend analysis to the Quality Assurance Committee..."	F 223		

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Resident #22 [and Resident #15]

Note:The facility submitted a self-report to the Bureau of Health Care Quality and Compliance (Bureau) prior to the survey regarding an incident of alleged sexual abuse by Resident #15 toward Resident #22 which occurred in December of 2008.

Resident #15 was a 57 year old male admitted 1/9/08, with diagnoses including Depressive Disorder, Hyperlipidemia, Esophageal Reflux, Diabetes Mellitus Type II, Epilepsy, Cerebral Vascular Accident, Malignant Neoplasm Mouth, Incontinence of Urine, Psychosis, Schizophrenia, Dementia, and Anemia.

Resident #22 was a 54 year old female admitted 8/12/08, with diagnoses including Hypoxemia, Pneumonia, Esophogeal Reflux, Thrombocytopenia, Convulsions, Schizophrenia, Hypothyroidism, and Mental Retardation.

The self report initially submitted by the facility via facsimile 1/2/09 indicated the following:
"Date of Incident: December 31, 2008
Person Involved: (Resident #22) / (Resident #15)
Type of Abuse: Alleged sexual abuse
Description of Incident: Resident reported she was allegedly raped by another resident.
Facility's Investigation: Resident's attending physician, family and North Las Vegas Police Department were notified. The North Las Vegas Police Department came to the facility and interviewed the resident. (Resident #15) was transferred to a different hall..."

The North Las Vegas Police Report concluded,

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"...Based on my investigation, I was unable to establish that a crime had occurred. Neither (Resident #15) or (Resident #22) were able to give me a statement as to what was going on. I made several recommendations to the staff to avoid such future problems, such as separating the men/women and keeping a better watch on (Resident #15)..."

The sexual assault could not be substantiated, however the following was noted concerning Resident #15's conduct towards Resident #22:

Resident #15's file, Nurses' Notes:
"12/31/08: (6am-2pm): ...Resident seen 4x went into the room of female (with) sexual gestures. Resident was told not to enter room, constantly."
"12/31/08: 1:30 pm received report from (Employee #3 - Social Worker), another pt (patient) (Resident #22) accused pt of sexual abuse. The police came in and did investigation, LSW (Licensed Social Worker) did investigate, pt was moved to another room away from the pt."

Staff interview revealed relative to Resident #15's attempted to approach Resident #22 on a continual basis:

One Licensed Practical Nurse (LPN) stated, "I thought they were trying to have a relationship. Sometimes she liked him and sometimes she screamed at him to get away from her. He kept on trying though..."

Another staff member indicated Resident #15 referred to Resident #22 as his girlfriend and even after being transferred from the 200 Hall, (he) had a daily practice of standing at the gate leading to the 200 Hall, telling staff repeatedly that

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he wanted to see his girlfriend, and was difficult to redirect from the 200 Hall gate.

Note: The 200 Hall gate separates the 200 Hall from the communicating corridor that leads to other portions of the building and is approximately 36" high, is lockable and has two leaves that span the corridor from the 200 Hall Nurse Station to the opposing wall

Resident #13 and #10 [and Resident #15]

Resident #15 was a 57 year old male admitted 1/9/08, with diagnoses including Depressive Disorder, Hyperlipidemia, Esophageal Reflux, Diabetes Mellitus Type II, Epilepsy, Cerebral Vascular Accident, Malignant Neoplasm Mouth, Incontinence of Urine, Psychosis, Schizophrenia, Dementia, and Anemia.

Resident #13 was a 56 year old female admitted 3/21/08, with diagnoses including Convulsions, Dementia, Esophageal Reflux, Acute Peptic Ulcer, Depressive Disorder, Symbolic Dysfunction, Abnormality of Gait, Mental Disorder, Nutrition Deficiency, and Prophylactic Measure.

Group interview with residents on the mid-morning of 9/2/09, indicated Resident #15 would walk around the facility exposing his buttocks and penis, exhibit sexual behaviors by masturbating in front of other residents, and wag his tongue inappropriately. The attendees further indicated there were times when Resident #15 was seen walking around the facility naked, and one time when Resident #15 did not have any pants on and had feces dropping on the floor as

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he walked down the 400 hallway.

Group interview continued with verification by three alert and oriented residents who reside in the 400 Unit hallway that they have observed Resident #15 approach Resident #13 and fondle her breasts. Resident #15 would, while getting close to her, put his hands in his pants and attempt to lower his pants and make repetitive lower body movements near her (appearing to be acts of masturbation). The residents indicated they have to watch him (Resident #15) very closely and yell at him when he attempts to approach Resident #13 because they are afraid he will grab her breasts or "do something sexual" again. The residents further indicated that this has been going on "for months".

Interview with the Administrator, Director of Nursing, and the Social Worker (Employee #3) on the afternoon of 9/2/09, they verified that they had never heard of Resident #15 being sexually inappropriate. The Social Worker indicated Resident #15 liked cars and would sometimes ask people what kind of car they were, and that Resident #15 only "teases" both male and female residents, saying "Boo-boo-boo-boo". The Social Worker further revealed, Resident #15 met with her daily to receive his $1.00/day spending money. Resident #15 would walk around the facility holding on to his pants because of the waist band being loose and/or the pants being too big.

Review of Resident #15's chart and further interview with staff revealed:

Psychiatric Progress Note dated 1/19/09: "(Resident #15) was transferred from hallway 2 to

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this unit, as a consequence of his underlying aggressiveness which he has recently been demonstrated. He apparently pushed a couple of other patients on the other units and has been somewhat difficult to redirect as a consequence of such..."

Psychiatric Progress Note dated 5/31/09: "...No marked aggression, combativeness, or inappropriate behavior has recently occurred, as was when he was on hallway #2..."

The documented Monthly Flow Records for the months of December of 2008, January, March, April and June of 2009 indicated behaviors of teasing, touching, tapping heads of other residents, and calling other residents names.

On 9/9/09 in the afternoon, interview with Resident #15's roommate (Resident #10), prior to Resident #15's relocation to the 200 Hall, revealed that the roommate did not like Resident #15's behaviors. The resident stated, "He's always getting in my face and shouting, I don't like it. I don't like the way he acts at all."

On 9/9/09 in the afternoon, interview with Resident #10 revealed he has observed Resident #15 on a regular basis demonstrating behaviors of getting close to residents' faces, shouting repetitive noises in their faces for a lengthy period of time, and sometimes pushing residents.

Group Interview Residents [and Resident #16]

Resident #16 was a 60 year old male admitted 11/2/07, and readmitted 7/15/09, with diagnoses including Schizophrenia, Chronic Airway

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Obstruction, Diabetes Mellitus Type I, Hyperlipidemia, Bipolar Disorder, Hypothyroidism, Coronary Arthrosclerosis, Dementia, Psychosis, Dysphasia, and Encephalopathy.

Summerlin Medical Center Transfer Summary dated 7/6/09: Discharge diagnoses: 1. Legal 2000 status; 2. Dementia; 3. Psychosis; 4. Schizophrenia; 5. Combativeness; 6. Dysphasia; 7. Encephalopathy; 8. Diabetes Mellitus; 9. Pneumonia; 10. Obstructive Sleep Apnea; 11. Seizure Disorder; 12. Anemia; 13. Chronic Obstructive Pulmonary Disease; 14. Left Eye Blindness; 15. Chronic Smoker; 16. Urinary Tract Infection, and further stated discharge instructions: "Transfer patient to Las Vegas Mental Health when bed available...Follow up with Las Vegas Mental Health assigned MD."

Group interview with residents on the mid-morning of 9/2/09, the majority (7 of 8) residents indicated that Resident #16 was "loud and threatening". They indicated they did not feel comfortable and safe because of threats that Resident #16 had made toward them. Two male residents added that Resident #16 had threatened to kill them with a machine gun and they were afraid of Resident #16.

On 9/2/09 at 11:30 AM, the Social Worker indicated Resident #16 had an "authoritative voice" that may scare residents.

Resident #29 [and Employee #6]

Resident #29 was a 72 year old female admitted 11/20/08 with diagnoses including Diabetes Mellitus, Dementia, Hypertension,

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Hypothyroidism, Arthropathy, Constipation, Anemia, Tear Film Insufficiency, Headache, Esophageal Reflux, and Psychosis.

The facility submitted a self-report to the Bureau regarding an incident of alleged physical abuse by a CNA toward Resident #29 reported 6/16/09, 7:15 PM, stating:

"Date of incident: June 14, 2009. Person Involved: (Resident #29). Type of Incident: Allegation of physical abuse. Description of Incident: Per Nurse's report, (Resident #29) complained of left sided cheek pain. Nurse on duty observed left sclera with presence of blood shots with minimal swelling noted to left cheek under eye. (Resident #29) is alert, oriented X 3. Per (Resident #29's) statement, 'the CNA came into my room, took some towels I had and CNA told me not to have any extra towels' (Resident #29) added, 'I told CNA I wanted them so I could take a bath and I was lying down on my bed when the CNA took the towels, I started to get up when CNA struck me on my left side near temple and knocked me back on my bed'."

The facility's follow up report completed by Employee #12 and submitted June 19, 2009 at 17:38 (5:38 PM), indicated the allegations of physical abuse were unsubstantiated, with a follow up report stating as follows:

"On Tuesday, June 16, 2009, per nurse report that resident (Resident #29) told here (sic) she had been hit by one of the workers. When I, (Staff Developer (Employee #12)) spoke with (Resident #29) and (Employee #18) this resident, (#29), describe the CNA who she said hit her was a dark, heavy girl with braided her (hair) and a

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scarf. Per resident statement, Monday the CNA asked me if I had any towels and I stated yeah I need them to take a bath. The CNA hit me with her fist right up here by my temple and knocked me down on the bed. She took the towels and said we're not allowed to have any towels. When I (Employee #12, Staff Developer) asked (Resident #29) when did this happen, she stated, 'Monday morning around 11 before lunch' Resident is alert and oriented times three. The CNA the resident described is (Employee #6) who works a double on Sundays from 6a (AM) until 10p (PM) and Monday from 2p (PM) until 10p (PM). When (Employee #6) reported to work on Tuesday evening at 2pm I asked (Resident #29) to show me the girl she was talking about and she pointed to (Employee #6) who is a dark, heavy girl wearing braids in her hair and a scarf.

Interview with (Employee #6) @ (at) 3pm:
I asked (Employee #6 what happened on Monday between her and this resident. Per (Employee #6's) statement: The incident with the towels that (Resident #29) is talking about happened on Sunday. I went into (Resident #29's) room and I took the towels from her because everyday she takes all the towels and place in her room. (Resident #29) became violent towards me. She scratched me and tried to bite me, but I didn't touch her. I (Employee #12) asked her who did she report to and she stated, (unknown employee name), but she didn't report the incident about the scratch only regarding the towels. (Employee #6) was sent home on suspension pending investigation on June 16, 2009 and terminated on June 17, 2009 for failure to follow safety rules of the facility with previous violation noted."

The Shepherd Eye Center Ophthalmologist

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Report for Resident #29 dated 6/19/09 stated, "Pt (patient) here after 7 yr (year) absence with complaint of sharp pain, redness and swelling around OS (left eye) x 5 days after being hit in OS on Sunday...Mental Status: A and O (alert and oriented) X 3: knows name, time, and place. Mood: normal...Biomicroscopy...OS same as OD (right eye) except: Conjunctiva - inferior temporal subconjunctiva hemorrhage...Diagnosis: 1. Diabetes without sign of retinopathy type II uncontrolled; Subconjunctival Hemorrhage, Dry Eye Syndrome, Refractive Error."

There was no documented evidence the facility conducted a complete investigation following the allegations of physical abuse by a CNA towards a resident. There was no documented evidence that the facility investigated the cause of the physical injury on Resident #29's eye and cheek. There was no documented evidence that the facility reported the incident to the North Las Vegas Police Department. There was no documented evidence that the facility interviewed other residents in the same unit being cared for by the same CNA regarding whether they have witnessed or experienced any physical abuse by Employee #6 (employed 6/24/08).
Surveyor: 21794

Residents #35, #36, #37, and #38 [and Resident #33]

Resident #33 was a closed record review. This resident was an 83 year-old male admitted to the facility on 6/10/09, and discharged on 8/3/09, with diagnoses including Delusional Disorder, Episodic Mood Disorder, Dementia, Chronic Ischemic Heart Disease, Hypertension, Diabetes Mellitus,

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Congestive Heart Failure Not Otherwise Specified, Chronic Kidney Disease Not Otherwise Specified and Pure Hypercholesterolemia.

Record review:

The Discharge Summary from North Vista Hospital, dated 6/10/09, indicated one of the documented reasons for admission to the hospital was due to "inappropriate sexual behaviors." At the time of discharge, the resident's mental status examination indicated, "Patient is not having sexual preoccupations or aggressive behaviors."

Dr. (Physician Name)'s Admission History and Physical, dictated on 6/12/09, indicated in the fourth paragraph, "He has had behavior issues including inappropriate sexual behaviors."

The resident's initial plan of care, dated 6/10/09, revealed no documented evidence that the resident's history of inappropriate sexual behaviors was specifically addressed. The initial plan did indicate that the resident was to be on psychotropic medications with monitoring of any possible medication induced side effects.

Further review of the record did provide evidence that the facility was monitoring sexually inappropriate behavior and the resident's resistance of care, however, the medication record flow sheet was not accurate to or in coordination with the reported accounts of the resident's inappropriate sexual behaviors.

Two days following admission the resident was displaying aggressive, inappropriate sexual behaviors directed towards others. It was indicated in a Nurse's Note, dated 6/12/09 at

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2200 (10:00 PM), "Res. noted to reach out and grab female res. and staff on the chest area in a sexual manner."

In a Nurse's Note, dated 6/15/09 at 0600 (6:00 AM), "Continues to makes gestures with his hands encouraging them to come closer. Monitored for inappropriate sexual advances to female residents."

At 0830 (8:30 AM) on 6/15/09, in the Nurse's Notes, "Following behind residents attempting to touch them."

The inappropriate sexual behaviors displayed by the resident and actually observed by staff (on 6/12/09 and two separate events on 6/15/09) were not documented in the resident's Medication Administration Record (MAR) as required to assist in monitoring the resident's Anti-Psychotic medication (Risperdal and Seroquel).

Additional entries in the Nurse's Notes revealed the resident continued to display inappropriate sexual behaviors. An entry on 6/18/09 at 2200, noted that the resident was "sexually inappropriate to residents x (times) 1."

An entry in the Nurse's Notes on 6/19/09 at 2130 (9:30 PM), again revealed that the resident was sexually inappropriate with one female resident. The resident was apparently redirected successfully by staff as indicated in the entry.

A Social Service Progress Note, dated 6/21/09, indicated that staff have acknowledged the resident's inappropriate sexual behaviors and attempts to touch female staff breast and genitalia, but was redirectable. In the same note,

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the social worker indicated the resident was compliant with facility rules and care. However, there was no mention that this resident was sexually inappropriate with his female peers as evident by entires in the Nurse's Notes.

The first evidence of a care plan identifying the resident's inappropriate sexual behavior was dated 6/22/09. The Goal was noted as "Resident #1 (name) will exhibit socially inappropriate behavior no more than twice weekly through next review."

A Nurse's Notes entry on 7/1/09 at 1800 (6:00 PM), revealed that nursing staff received a TO (telephone order) from Dr. (Physician Name) for the resident to be seen by a Psychiatrist for Delusional Disorder.

An entry in the Pharmacist Progress Note/Medication Regime Review on 7/17/09, noted, "Resident is pending psychiatric eval. following recent Gero-psych (geriatric psychiatric) admit."

Additional calls were placed to Dr (Physician Name) on 7/24/09 at 1700 (5:00 PM) and 7/27/09 at 1445 (2:45 PM), for a Psychiatric evaluation for the resident. The entry on 7/27/09 indicated, "Dr. (Physician Name) states psychiatric evaluation not needed d/t (due to) pt. (patient) stability at this time."

The facility's Telephone Orders dated 7/1/09, indicated the resident was okay to to be seen by the Psychiatrist. However, as indicated above, documentation in a Telephone Order on 7/27/09, indicated the resident was stable and no psychiatric evaluation was required at that time.

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As indicated in a Nurse's Notes entry on 7/30/09 at 1700, the resident continued to display inappropriate sexual behaviors. It was noted that Female residents indicated the resident was "flirting" with them.

On 7/31/09 at 11:00 AM, it was documented in a Nurse's Note, "Resident making foul nasty remarks to residents and to the lady staff members." It was indicated in the note that the resident was verbalizing explicit sexual acts towards residents. It was further indicated that staff would monitor resident to keep him away from the lady residents.

On 8/3/09 at 1200 (12:00 PM), it was indicated in the Nurse's Notes that the resident was to be transferred to 200 Unit (Alzheimer unit) for alleged sexual innuendos toward other residents. Staff indicated in the note that this behavior wasn't witnessed.

At 1500 (3:00 PM) on 8/3/09, another entry indicated that the resident continued to make inappropriate gestures and innuendos towards residents while sitting in the common area on the unit.

A 4:30 PM entry in the Nurse's Notes indicated the social worker received an order to "Legal 2000" the resident to North Vista Emergency Department for admit to their Gero-Psych Unit. The resident was transferred out by 5:45 PM on 8/3/09.

On 8/3/09, two entries were noted on the Physician Telephone Orders, the first was an order for a Psychiatric evaluation and the second

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order was to Legal 2000 the resident to North Vista Hospital.

Note: "Legal 2000" is a reference to the State of Nevada's legal competency process. It is being used here as a short-hand reference for the facility to transfer the resident to an acute care hospital's emergency department for psychiatric evaluation and legal adjudication.

The care plan generated on 6/22/09, had no evidence that it was updated following reports of additional inappropriateness by the resident. A Comprehensive Care Plan was generated on 8/3/09, following the final observations of sexual inappropriate behaviors and subsequent transfer from the facility.

A document maintained in the resident's record, dated 8/3/09, contained documented statements from four different residents (Resident #35, Resident #36, Resident #37, and Resident #38) and one female staff member. Four unsampled residents, Resident #35, Resident #36, Resident #37, and Resident #38 acknowledged that the resident was sexually inappropriate.

It was noted in the 08/03/09 document that on 7/31/09, the resident went to Resident #35's table in the dining room and grabbed her arm and was trying to touch her shirt. During the interview with Resident #37, he indicated that Resident #33 was touching Resident #35's breast and when he saw staff stopped.

It was further noted in the document that the resident had touched the leg of Resident #36 and made inappropriate sexual comments to her on 7/31/09. Resident #38 was noted to say that she

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hadn't witnessed anything on 7/31/09, but acknowledged that the resident makes inappropriate sexual comments to her and other females.

The above aforementioned document, dated 8/3/09, was the first evidence of a facility investigation or reporting of the resident's ongoing behavior. The final report was completed on 8/6/09. The investigation only covered the event of sexual inappropriateness on 7/31/09.

Interview:

On 9/10/09, the Director of Nursing was interviewed and asked if additional documentation, reports or investigations were available for review concerning this resident's behaviors. The Director of Nursing acknowledged that there were no other care plans or evidence of follow-up available.
Surveyor: 27178

Resident # 25 [and Resident #26]

Resident #25 was a 53 year old female admitted on 7/14/09, with diagnoses including Depressive Disorder, Degenerative Disc Disease of Cervical Spine and Lumbosacral Spine, Chronic Pain Syndrome, History of Melanoma, History of Deep Vein Thrombosis, Carpal Tunnel Syndrome and Hypertension.

Resident #25's Fall Risk Assessment date 7/14/09 revealed, Resident #25 was alert and oriented x 3 (people, place and time). The Minimum Data Set dated 8/5/09 revealed, Resident # 25's short term memory and long term

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memory were intact; Resident #25 was able to make self understood to others, had clear speech and had the ability to understand others.

The Social Services Progress Notes dated 7/30/09 revealed, Resident #25 was alert and oriented, cooperative and pleasant. Resident #25's short term memory and long term memory were intact. Resident #25 was able to identify staff by name and face recognition; Resident #25 was able to engage in meaningful conversation and was able to verbalize her needs with clear speech that was understood.

The Activity Progress Notes dated 7/30/09 indicated, Resident #25 was alert and oriented x3. Resident #25 continued to be the President of the Resident Council who volunteered for set up of bingo, helped other peers and staff.

On 9/10/09 at 11:30 AM, Resident #25 revealed that, about two weeks ago, Resident #25 was walking into the dining area. Resident #26 was in his wheelchair, wagging his tongue. As Resident #25 was passing through Resident #26's direction, Resident #26 suddenly reached out and grabbed Resident #25's chest. According to Resident #25, many residents had witness the incident along with two Certified Nurse Assistants. The CNAs who witnessed the incident quickly walked up to Resident #26 and told Resident #26 to stop via his native language.

Resident #25 revealed she did not report the incident to the Director of Nurses (DON) at once since the two CNAs witnessed the incident. Resident #25 was unable to remember the CNAs.

Resident #25 further revealed Resident #26 did

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not completely stop the behavior. Resident #25 revealed a second incident that happened. "About a week ago, he tried to grab me again but I slapped his hand." Resident #25 indicated she promptly reported this incident and the incident from two weeks prior to the DON, for she was afraid to get in trouble for slapping Resident #26's hand.

Resident #25 further revealed, "The DON told me she'd take care of it."

Resident #25 indicated Resident #26's playing with his tongue and reaching for people and trying to grab made her uncomfortable. Resident #25 further stated, "...but this is a normal occurrence and behavior," for Resident #26.

Resident #25 further indicated she had witnessed Resident #26 tried to grab Resident #39 on several occasions.

Resident #39 [and Resident #26]

Resident #39 was a 46 year old female admitted on 10/07/08, with diagnoses including Depression Disorder, Right Hemispheric Cerebrovascular Accident with Left Hemiparesis, Diabetes Mellitus, and Seizure Disorder.

Review of the Social Service Progress Notes dated 8/19/09 revealed, Resident #39's short and long term memory were intact. Resident #39 was able to engage in meaningful conversation, able to identify staff by name and face recognition. Resident #39 was able to verbalize her needs with clear speech which was understood and was able to understand others.

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F 223	Continued From page 21 On 9/10/09 in the afternoon, Resident #39 revealed that Resident #26 had tried to touch and/or grab her many times. Resident #39 stated, "I asked him to stop but he won't stop; He would stop for that moment but the next day, he would try and touch me or try to ask for kisses from me. I think he is just lonely and sick in the head." Resident #39 denied reporting the incidents to any of the staff members due to, "They see him do that to everyone, even with the staff. He would try and touch them too and ask for kisses; It's his normal behavior. Me, I would fight back. I would show him my fist and ask him if he wants my fist instead. When I do that, he would leave and go to a different person. I don't think he would hurt anyone but he just likes to grab and touch and ask for kisses. But he shouldn't be doing that. It's not right." On 9/10/09 at 1:30 PM, Employee #13 revealed, Resident #26 was a loving person who would ask for kisses via gestures. Employee #13 further revealed, Resident #26 would attempt to touch other residents in the Activity Room but was easily re-directed. Employee #13 also revealed at times Employee #13 would position the other residents' wheelchairs very close to the rectangular tables in front of them as to not have so much space in which Resident #26 could reach the residents. Employee #13 continued, Resident #26's behavior had been an ongoing issue in which at times had disrupted activities in the activity room	F 223		

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due to needing to relocate Resident #26's sitting arrangement as not to bother other residents.

Employee #13 revealed since Resident #26's behavior had been ongoing, it was almost viewed as a normal behavior .

[Resident #26]

Resident #26 was a 55 year old male admitted on 12/23/08, with diagnoses including Depressive Disorder, Anemia, Hypertension, Dementia, Chronic Ischemic Heart Disease and End Stage Renal Disease.

Resident #26 was transferred to an acute care hospital emergency department on 9/5/09, for evaluation and appropriate placement.

The Social Service Quarterly Progress Notes dated 6/9/09 revealed, Resident #26 sometimes would "get agitated and aggravated by peers and would yell and curse them and sometimes hit them or attempt to hit them."

The Minimum Data Set dated 6/10/09 revealed, Resident #26 had verbally abusive behavioral symptoms and physically abusive behavioral symptoms.

The Comprehensive Plan of Care review revealed:
- An initial care plan regarding Resident #26's Episodes of Unwanted Behaviors: Resident sexually inappropriate with staff and residents was written on 9/5/09;
- A Temporary Care Plan dated 6/19/09 was completed regarding an altercation incident with

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another resident on 6/18/09; and
- There were no other care plans written addressing Resident #26's behavior.

The facility's Self-Report to the Bureau dated 9/6/09 revealed, on 9/5/09, Resident #26 was seen touching female residents whenever he was in the Activity Room. Resident #26 was placed on a 1:1 and every 15 minutes monitoring on 9/5/09. Resident #26 was transferred to an acute hospital on 9/5/09, due to needed appropriate placement secondary to hypersexuality.

The Activity's Annual Progress Notes dated 9/3/09 revealed, Resident #26's behavior during ongoing programs have disrupted and agitated other peers. Resident #26 would fondle female peers especially female peers that were physically challenged.

The Social Service Progress Notes dated 9/5/09 revealed, Employee #13 had reported that in the Activity Room, Resident #26 would attempt to touch, fondle or kiss any female residents especially those who were physically challenged. Employee #13 would remove the residents away from Resident #26. Resident #26's behavior had been a continued behavior for several months.

The Social Service Progress Notes dated 9/5/09 further revealed, on 9/5/09, while Resident #26 was being showered, the Social Worker witnessed Resident #26 attempted to grope the CNA.

The Social Worker attempted to talk to Resident #26 regarding his inappropriate behavior, but Resident #26 started blowing kisses at her.

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F 223	Continued From page 24 On 9/10/09 at 2:30 PM, a meeting with the Administrator, Director of Nurses (DON) and Social Worker revealed the following: The Social Worker revealed, Resident #26 was friendly who liked touching other people, giving hugs and giving kisses, may it be by blowing kisses or gesturing to kiss. The Social Worker further revealed, Resident #26 would openly extend his arms to ask for hugs and/or to reach anyone close to him. The Social Worker further revealed, the Social Services Quarterly Notes, dated on 6/9/09, was written by a part-time Social Worker. The Social Worker stated, "I don't know where she (part-time Social Worker) got her information from. I didn't read her notes." The Social Worker revealed, she was not aware of Resident #26's inappropriate behaviors until 9/5/09. It was then that the Social Worker witnessed Resident #26 trying to grope the CNA while Resident #26 was being showered. This incident prompted the Social Worker to contact Resident #26's primary physician who in turn ordered for Resident #26 to be transferred to an acute hospital emergency room for evaluation and appropriate placement. The Administrator revealed, a care plan was initiated sometime in June 2009 addressing Resident #26's inappropriate sexual behaviors. The Administrator further revealed, the Charge Nurses initiated the care plans. The information from the other Social Worker (part time Social Worker) regarding "cursing and hitting other residents could have been from many years ago."	F 223		

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The DON was unable to provide a copy of the care plan written in June 2009 addressing the Resident #26's inappropriate behaviors.

The DON denied receiving any reports or complaints from Resident #25 regarding any of the two incidents involving Resident #26, hence the lack of Self-Report to the Bureau.

Resident # 40 [and Resident #15]

Resident #40 was a 46 year old male admitted on 7/2/09, with diagnoses including Depressive Disorder, Psychosis, Diabetes Mellitus, Asthma and Osteoarthritis.

On 9/2/09 at 5:00 PM during medication pass observation, Resident #40 was waiting for his medications to be given by Employee #19.

Resident #40 was in a wheelchair positioned right in front of the medication cart in the 400 Hall, as Employee #19 was preparing another resident's medications in front of Room 415.

Resident #15 walked by and briefly asked Employee #19 for his medications. Employee #19 informed Resident #15 that his medications were going to be given in his room.

As Resident #15 turned to head back to his room, he briefly stopped and approached Resident #40 and uttered foreign words to Resident #40.

Resident #15 was face to face with Resident #40 and repeated the same foreign words three times until Resident #40 repeated back the words to Resident #15. Resident #15 then, walked back to

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his room.

A few minutes passed, Resident #15 went back to Employee #19 for his medications. Employee #19 informed Resident #15 she was going room to room and that she would meet Resident #15 in his room.

Resident #15 turned and approached Resident #40 again, and repeated the same foreign words to Resident #40 and did not stop until Resident #40 repeated the foreign words Resident #15 had said. Resident #15 smiled, and went back to his room.

A couple of minutes passed, Resident #15 went back to Employee #19 and asked for his medications. Employee #19 instructed Resident #15 to return to his room and that his medications would be given in his room. Resident #15 approached Resident #40 and repeated the same foreign words to Resident #40 who was quietly waiting for his medications.

Resident #40 would not respond as Resident #15 kept repeating the same foreign words to Resident #40.

Resident #40 stated, "I don't want to say it anymore" and started crying. Employee #19 continued to prepare medications as the events occurred.

Resident #15 kept repeating the same foreign words to Resident #40 as Resident #40 continued to cry. Only after Resident #40 repeated the same foreign words that Resident #15 stopped. Resident #15 soon returned to his room and, at the same time, Resident #40 stopped crying.

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These cycle of events went on for 15 minutes until Employee #19 reached Resident #15's room.

On 9/3/09 at 4:00 PM, interview with Resident #40 revealed, "He's like that. Sometimes, it bothers me and sometimes, not. That's his usual behavior. He does that with other people and he walks around the facility. He bothers some people; Some people are okay with what he does. They don't say anything. Sometimes he gets to me and makes me upset. The workers see him do these things but they don't do anything. They are used to him, I guess, that's why they don't do anything. He does say funny words to people not just to me and he gets very close to people. Sometimes he scares people. I get scared sometimes."

[Resident 15]

On 9/2/09 at 3:30 PM, Employee #20 revealed, Resident #15 was in the 600 Hall at one point. Employee #20 further revealed, "one time, he ran out of clothes and he was seen walking around the hall naked."

On 9/2/09 in the afternoon, Employee #21 revealed Employee #15 liked to tease other residents, most especially the ones who could not complain. He would tell them foreign words or would ask about cars, if you're a chevy or something."

On 9/3/09 at 11:10 AM, Employee #22 revealed Employee #15 wore big pants in which Resident #15 would need to hold on to, to prevent the pants from falling off. "Sometimes, because the

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F 223	Continued From page 28 pants were too big, the back part would hang down and show his buttocks. He doesn't like to use diapers." [Resident #16] Employee #22 further revealed, Resident #16 would sometimes scare the people around him due to his yelling and screaming. "He would curse sometimes but it's not directed at anyone. He would just yell and scream when he is upset, but not at anyone in particular."	F 223		
F 226 SS=H	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 12211 Based on observation, interview, document review, and record review, the facility failed to implement written policies and procedures that prohibit mistreatment and abuse of residents and misappropriation of resident property, and to ensure proper screening of staff for employment and training of staff in prevention, identification, investigation, protection, and reporting of resident mistreatment events. Findings include: Note: Individuals identified with brackets [ ] are the offending persons.	F 226		

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Policy Review

On the morning of 9/3/09, the facility submitted a policy regarding abuse and neglect (undated) to the State Agency (Bureau of Health Care Quality and Compliance (Bureau)) surveyors, which stated as follows:

"TOPIC: PROHIBITING ABUSE
RESPONSIBLE STAFF: All staff, All Departments
REPORTS TO: Administrator, Director of Nursing, and/or Community Coordinators
Purpose: To prohibit abuse of residents from any source. To promote the well-being of residents by providing a safe and supportive environment. To maintain the resident's right to be free from verbal, sexual, physical, mental abuse, corporal punishment and involuntary seclusion.
Definitions:
Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.
Verbal Abuse: The use of oral, written or gestured language, that willfully includes disparaging and derogatory terms to residents or their families or within hearing distance, regardless of their age, ability to comprehend, or disability.
Sexual Abuse: Including but not limited to sexual harassment, sexual coercion, or sexual assault.
Physical Abuse: Hitting, slapping, pinching, kicking, or controlling through corporal punishment.
Mental Abuse: Including but not limited to humiliation, harassment, and threats of

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F 226	Continued From page 30 punishment or deprivation... Neglect: Failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness. Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful temporary or permanent use of resident's belongings or money without the resident's consent. Unusual Incident/Accident: An unusual incident and/or injury of unknown origin is used to describe a condition or situation involving a resident which is abnormal or unexpected, and not due to a known disease or known event. Examples of unusual incidents include, but are not limited to, abnormal bruising, scratches, skin alterations, drug abuse, etc. Catastrophic Behaviors: Occurrences of resident to resident abuse or aggression shall be documented on the facility Incident Report form and reported immediately to administration. The interdisciplinary team will be responsible for developing, implementing, and communicating a plan of care with intervention strategies to prevent or manage abusive episodes. Monitoring and reassessment of the resident and the effectiveness of his/her plan of care will occur as per plan of care policy. The Administrator, Director of Nursing or designee will be responsible for maintaining data and reporting pattern and trend analysis to the Quality Assurance Committee. Policy: 1. Screening of Staff: a. All potential employees will be screened as a part of the application process to determine of (sic) there is a history of abuse, neglect, or mistreatment of individuals. This will include completion of the Criminal Background form	F 226		

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which will be sent to the Department of Health and Registry if applicable.
b. Screening will include contact with known, current employers and known, past employers.
c. Screening will also include checking with the appropriate Licensing Boards and Registries.
2. Training of Staff: Employees must be trained through orientation and ongoing in-services about the following:
i. Appropriate intervention to deal with aggressive and/or catastrophic reactions of residents.
ii. How staff should report information about allegations without fear of reprisal.
iii. How to recognize signs of burnout, frustration and stress that may lead to abuse.
iv. What constitutes abuse, neglect, and misappropriation of resident property.
3. Prevention:
a. Personnel, residents, visitors, etc. are encouraged to promptly report incidents of suspected resident abuse or neglect to the facility administration, without fear of reprisal. All alleged or suspected violations involving mistreatment, abuse or neglect, including injuries of unknown origin such as bruising and/or skin tears will be investigated by the Administrator and/or Director of Nursing.
b. Following a report of suspected abuse or neglect, administration will designate a resident advocate (i.e., Social Services) to support the resident through his/her feelings about the incident and his/her reaction to involvement in the investigation. The designated resident advocate will coordinate development or care plan intervention that may assist the resident in successfully dealing with the occurrence of abuse or neglect.
4. Identification:Abuse and neglect in nursing facilities is a high priority. Any type of abuse

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constitutes a violation of resident rights. The following incidents should be assessed for possible abuse.
*Burns (unusual location or type)
*Injury to head, scalp or face
*Hematomas (unusual location, in shape of fingerprints, presence of other injuries in different stages of healing.)
*Fractures, falls, or evidence of physical restraint (contractures or red marks on wrist)
*Abnormal or suspicious behavior of resident (fearful or agitated, overly quiet and passive, expressing fear of caregiver or fear of opposite sex caregivers.
*Decline in physical or mental status.
*Since every resident in long term care is at risk for abuse due to their diminished capacity, care must be taken by every staff member to identify individuals at greatest risk for abuse and monitor them closely for potential physical, emotional, or spiritual harm.
*All incidents of alleged abuse or neglect will be summarized. Trends will be identified, recommendations will be made, and action plans will be developed, implemented and follow up will insure ongoing compliance.
5. Investigation:
a. Any person who suspects that abuse, neglect, or misappropriation of property may have occurred, will immediately report the alleged violation to the facility administration and advocacy agencies.
b. The facility administration will immediately notify the Department of Health Services, Adult Protective Services, Long Term Care Ombudsman and/or local law enforcement authority.
c. The facility administration will initiate the investigation process by interviewing all staff and

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residents having any knowledge of the allegation immediately.
d. The Director of Nursing will insure notification of responsible parties and physicians of the alleged incident.
e. The facility administration will complete the investigation within five (5) days of the allegation and will document all interviews, including the date, time, and content of the interview.
f. Following an allegation, the facility will implement increased supervision and monitoring of residents as needed to insure that all residents are safe from any further abuse.
6. Protection:
a. If the complaint alleges abuse by staff, the facility will take steps to protect the residents from any further abuse. This will include suspension of the staff member who was named in the allegation until the investigation has been completed. If the allegations of staff abuse is substantiated the alleged perpetrator will be terminated.
b. If the alleged perpetrator is a resident, the nursing staff will initiate intervention to provide immediate protection of residents until the interdisciplinary team can convene to review the current plan of care and make any necessary revision in order to insure the safety of others.
7. Reporting/Responses:
a. After the investigation is complete, the facility administration will document a summary of its findings as to whether the alleged abuse was substantiated or unsubstantiated and the report of its findings will be forwarded to the agencies which were notified at the beginning of the investigation, as well as notification of the resident's physician and the resident and/or his/her legal representative.
b. If abuse is substantiated, notification of the

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State Nurse Aid Registry and/or State Board of Nursing will be made by the Director of Nursing or designee.
c. If it is determined that abuse has been substantiated, the facility Quality Assurance Committee will review the findings and determine if any changes in facility policies and procedures are required to prevent further potential for abuse.

Resident #13 [and Resident #15]

Resident #15 was a 57 year old male admitted 1/9/08, with diagnoses including Depressive Disorder, Hyperlipidemia, Esophageal Reflux, Diabetes Mellitus Type II, Epilepsy, Cerebral Vascular Accident, Malignant Neoplasm Mouth, Incontinence of Urine, Psychosis, Schizophrenia, Dementia, and Anemia.

Resident #13 was a 56 year old female admitted 3/21/08, with diagnoses including Convulsions, Dementia, Esophageal Reflux, Acute Peptic Ulcer, Depressive Disorder, Symbolic Dysfunction, Abnormality of Gait, Mental Disorder, Nutrition Deficiency, and Prophylactic Measure.

Group interview with residents on the mid-morning of 9/2/09, three alert and oriented residents who reside in the 400 Unit confirmed that they have observed Resident #15 approach Resident #13 and fondle her breasts. Resident #15 would, while getting close to Resident #13, put his hands in his pants and attempt to lower his pants and make repetitive lower body movements near her (appearing to be acts of masturbation). The residents indicated they have to watch him (Resident #15) very closely and yell

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at him when he attempts to approach Resident #13 because they are afraid he will grab her breasts or "do something sexual" again. The residents further indicated that this has been going on "for months".

As indicated above, the facility did not meet their policy and regulatory requirements by NOT:
a) Sensitizing staff (adequate training) to recognize abusive practices;
b) Identifying ongoing abusive practices;
c) Taking adequate measures to prevent and/or mitigate abusive practices;
d) Conducting sufficient investigations when abusive practices occur, or allege to occur, to properly establish the validity of the existance of abusive practices;
e) Reporting abusive practices to all pertinent authorities having jurisdiction.

Resident #22 [and Unidentified Male]:

Nurse's Noted dated 10/3/08, 1830 (6:30 PM) stated the following: "Res (resident) was in bed when (unidentified male resident) from the adjacent room came up to her bed and started scratching on the face. Res started screaming and CNA who was doing one-on-one with another res walked into the room to find res bleeding on the face from scratch marks. CNA separated the two res and sought help from fellow nsg (nursing) staff who responded promptly. Res appears shaken. Brought to nsg station for evaluation and safety. MD paged for update." (According to the Nurses' Notes, Resident #22 was transferred to Valley Hospital Emergency Room and treated.)

There was no documented evidence the facility

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submitted a report to the Bureau regarding the 10/3/08 incident. There was no documentation the facility reported the physical abuse to the North Las Vegas Police Department.

As indicated above, the facility did not meet their policy and regulatory requirements by NOT:
a) Taking adequate measures to prevent and/or mitigate abusive practices;
b) Conducting sufficient investigations when abusive practices occur, or allege to occur, to properly establish the validity of the existance of abusive practices;
c) Reporting abusive practices to all pertinent authorities having jurisdiction.

Resident #22 [and Resident #15]

Resident #15 was a 57 year old male admitted 1/9/08, with diagnoses including Depressive Disorder, Hyperlipidemia, Esophageal Reflux, Diabetes Mellitus Type II, Epilepsy, Cerebral Vascular Accident, Malignant Neoplasm Mouth, Incontinence of Urine, Psychosis, Schizophrenia, Dementia, and Anemia.

Resident #22 was a 54 year old female admitted 8/12/08, with diagnoses including Hypoxemia, Pneumonia, Esophogeal Reflux, Thrombocytopenia, Convulsions, Schizophrenia, Hypothyroidism, and Mental Retardation.

The self report initially submitted by the facility via facsimile 1/2/09 indicated the following:
"Date of Incident: December 31, 2009
Person Involved: (Resident #22) / (Resident #15)
Type of Abuse: Alleged sexual abuse
Description of Incident: Resident reported she

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was allegedly raped by another resident. Facility's Investigation: Resident's attending physician, family and North Las Vegas Police Department were notified. The North Las Vegas Police Department came to the facility and interviewed the resident. (Resident #15) was transferred to a different hall..."

The North Las Vegas Police Report concluded, "...Based on my investigation, I was unable to establish that a crime had occurred. Neither (Resident #15) or (Resident #22) were able to give me a statement as to what was going on. I made several recommendations to the staff to avoid such future problems, such as separating the men/women and keeping a better watch on (Resident #15)..."

The sexual assault could not be substantiated, however the following was noted concerning Resident #15's conduct towards Resident #22:

Review of Resident #15's file revealed Nurses' Notes with the following entries dated 12/31/08:

"12/31/08: (6am-2pm): ...Resident seen 4x went into the room of female (with) sexual gestures. Resident was told not to enter room, constantly."
"12/31/08: 1:30 pm received report from (Employee #3 - Social Worker), another pt (patient) accused pt of sexual abuse. The police came in and did investigation, LSW (Licensed Social Worker) did investigate, pt was moved to another room away from the pt."

During the course of the survey, staff verified that Resident #15 attempted to approach Resident #22 on a continual basis, as described below:

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One Licensed Practical Nurse (LPN) stated, "I thought they were trying to have a relationship. Sometimes she liked him and sometimes she screamed at him to get away from her. He kept on trying though."

Another staff member indicated Resident #15 acted like Resident #22 was his girlfriend and even after being transferred from the 200 Hall, (he) had a daily practice of standing at the gate leading to the 200 Hall and told staff he wanted to see his girlfriend and was difficult to redirect from the 200 Hall gate.

As indicated above, the facility did not meet their policy and regulatory requirements by NOT:
a) Sensitizing staff (adeqaute training) to recognize abusive practices;
b) Identifying ongoing abusive practices;
c) Taking adequate measures to prevent and/or mitigate abusive practices;

Group Interview Residents [and Resident #16]

Resident #16's chart included the Summerlin Medical Center Transfer Summary dated 7/6/09 which indicated the following discharge diagnoses: 1. Legal 2000 status; 2. Dementia; 3. Psychosis; 4. Schizophrenia; 5. Combativeness; 6. Dysphasia; 7. Encephalopathy; 8. Diabetes Mellitus; 9. Pneumonia; 10. Obstructive Sleep Apnea; 11. Seizure Disorder; 12. Anemia; 13. Chronic Obstructive Pulmonary Disease; 14. Left Eye Blindness; 15. Chronic Smoker; 16. Urinary Tract Infection, and further stated discharge instructions: "Transfer patient to Las Vegas Mental Health when bed available...Follow up with Las Vegas Mental Health assigned MD."

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F 226	Continued From page 39 Group interview with residents on the midmorning of 9/2/09, the majority (7 of 8) residents indicated that Resident #16 was "loud and threatening". They stated they did not feel comfortable and safe because of threats that Resident #16 had made toward them. Two male residents added that Resident #16 had threatened to kill them with a machine gun and they were afraid of Resident #16. As indicated above, the facility did not meet their policy and regulatory requirements by NOT: a) Sensitizing staff (adeqaute training) to recognize abusive practices; b) Identifying ongoing abusive practices; c) Taking adequate measures to prevent and/or mitigate abusive practices; d) Conducting sufficient investigations when abusive practices occur, or allege to occur, to properly establish the validity of the existance of abusive practices; e) Reporting abusive practices to all pertinent authorities having jurisdiction. Resident #29 [and Employee #6] Resident #29 was admitted 11/20/08, with diagnoses including Diabetes Mellitus, Dementia, Hypertension, Hypothyroidism, Arthropathy, Constipation, Anemia, Tear Film Insufficiency, Headache, Esophageal Reflux, and Psychosis. The facility's self report submitted June 16, 2009 19:15 (7:15 PM) via facsimile: "Date of incident: June 14, 2009. Person Involved: (Resident #29). Type of Incident: Allegation of physical abuse. Description of Incident: Per Nurse's report,	F 226		

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(Resident #29) complained of left sided cheek pain. Nurse on duty observed left sclera with presence of blood shots with minimal swelling noted to left cheek under eye. (Resident #29) is alert, oriented X 3. Per (Resident #29's) statement, 'the CNA (Certified Nursing Assistant) (Employee #6) came into my room, took some towels I had and CNA told me not to have any extra towels' (Resident #29) added, 'I told CNA I wanted them so I could take a bath and I was lying down on my bed when the CNA took the towels, I started to get up when CNA struck me on my left side near temple and knocked me back on my bed'." The facility's follow up report submitted June 19, 2009 at 17:38 (5:38 pm), indicated the allegations of physical abuse were unsubstantiated.

The Shepherd Eye Center Ophthalmologist Report dated 6/19/09 stated, "Pt (patient) here after 7 yr (year) absence with complaint of sharp pain, redness and swelling around OS (left eye) x 5 days after being hit in OS on Sunday...Mental Status: A and O (alert and oriented) X 3: knows name, time, and place. Mood: normal...Biomicroscopy...OS same as OD (right eye) except: Conjunctiva - inferior temporal subconjunctival hemorrhage...Diagnosis: 1. Diabetes without sign of retinopathy type II uncontrolled; Subconjunctival Hemorrhage, Dry Eye Syndrome, Refractive Error."

There was no documented evidence the facility conducted a complete investigation following the allegations of physical abuse by a CNA towards a resident: There was no documentation that the facility investigated the cause of the physical injury to Resident #29's left cheek and eye. There was lack of documentation that the facility

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interviewed other residents in the same unit being cared for by the same CNA regarding whether they have witnessed or experienced any physical abuse by Employee #6.

As indicated above, the facility did not meet their policy and regulatory requirements by NOT:
a) Sensitizing staff (adeqaute training) to recognize abusive practices;
b) Identifying ongoing abusive practices;
c) Taking adequate measures to prevent and/or mitigate abusive practices;
d) Conducting sufficient investigations when abusive practices occur, or allege to occur, to properly establish the validity of the existance of abusive practices;
e) Reporting abusive practices to all pertinent authorities having jurisdiction.

Resident #30 [and Employee #5]

Resident #30 was a 52 year old female admitted 4/17/09, with diagnoses including Diabetes Mellitus and Chest Pain.

The facility submitted a self report dated 4/24/09, which stated as follows:

"Date of Incident: April 22 and April 23, 2009.
Person Involved: (Resident #30).
Type of Incident: Allegation of verbal abuse by the AM-CNA (Employee #5) staff at the 300 Hall.
Description of Incident: Per social worker's report, (Resident #30) reported that a female (Afro-American) CNA was allegedly 'screaming' at her especially when (Resident #30) asked her to do something for her like, to change her bed sheets. (Resident #30) reported that the staff told

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her, 'Stop using the call light'. (Resident #30) informed the social worker that she does not abuse using the call light. (Resident #30) feels that she is being maltreated. 'No witness' per (Resident #30). The allegation was reported by (Resident #30) on April 23, 2009 at around 2:30 PM.

Facility's Intervention: Per Unit Manager's report, resident claimed CNA allegedly yelled and screamed when she talks to (Resident #30). Upon investigation, CNA was not assigned to (Resident #30), however, offered help since the CNA assigned to (Resident #30) was attending another resident. Per nurse's report "Staff on the unit, did not hear any screaming and yelling' upon investigation. Care planned. CNA involved was suspended, pending allegation of verbal abuse..."

The facility submitted a follow up report dated 4/24/09 indicating: Facility's Intervention: "CNA involved is now back on her regular working schedule however, is now assigned to another hall after three days suspension pending investigation. Conclusion: "The allegations were found to be unsubstantiated due to no witnesses and also (Resident #30's) diagnosis."

On the morning of 9/2/09, the Social Worker and the Director of Nursing (DON) were interviewed regarding the investigation of the above incident regarding verbal abuse allegations by Resident #30. The Social Worker (Employee #3) and the DON both indicated they did not substantiate the complaint due to lack of witnesses that that the verbal abuse occurred. They confirmed that they did not interview any residents in the adjacent rooms regarding whether they had overheard a CNA screaming. They further indicated they did

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not interview any other residents on the 300 Unit asking whether they had witnessed or been verbally abused by Employee #5 (employed 8/11/06).

As indicated above, the facility did not meet their policy and regulatory requirements by NOT:
a) Conducting sufficient investigations when abusive practices occur, or allege to occur, to properly establish the validity of the existance of abusive practices;

Resident #31 [and Employee #4]

Resident #31 was a 66 year old female admitted 7/10/08, with diagnoses including Hypotension, Dehydration, Chronic Obstructive Pulmonary Disease, Bipolar Disorder, Heat Stroke and Sun Stroke, Rhabdomyolysis, Hyposomality, Tobacco Use Disorder, Anxiety State, and Breast Neoplasm.

Chart Review: The Social Service Progress Notes dated 5/13/09, completed by a Social Worker (Employee #14) stated as follows:

"On May 13, 2009 this writer spoke with resident (Resident #31) regarding an incident that occurred on May 11, 2009. (Resident #31) stated she checked her checking account at Wells Fargo to see if her stimulus check had arrived. That upon reviewing her balance she learned she had less than $40 in the bank, that prior to this she had $991 dollars in the bank and had made no withdrawals. (Resident #31) advised she then approached staff (Employee #4) for her bank card and pin (personal identification number) as she had given this information to (Employee #4) for

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F 226	Continued From page 44 safekeeping. She also stated that she accused staff of taking her money (Employee #4), in particular. (Resident #31) advised that she was ignored by staff, that they advised her she came to the office and made accusations of someone stealing her money but did not explain what was going on. (Resident #31) advised she approached (Employee #4) and that (Employee #4) stated she didn't take her money and that she was going to give her bank card back. (Resident #31) advised (Employee #4) then disappeared for a while from the office and building. That upon her return she advised (Resident #31) to check her account again and when she did check her account there were several deposits made to her account (50, 150, 750). (Employee #4) then transported (Resident #31) in her car to the bank, during the transport, (Employee #4) advised her she didn't want her card anymore and nothing to do with her money. That (Employee #4) stated her mother had gotten a hold of the card and pin number and withdrew the money as she is ill (schizophrenia). (Resident #31) advised she withdrew $800 and left a balance of $171. (Employee #4) returned (Resident #31's) bank care (card) to her." The facility submitted a self report 5/13/09 via facsimile which states as follows: "Date of Incident: May 12, 2009 Person Involved: (Resident #31), (Employee #15 - title?), (Employee #16 - title?) (Employees). Type of Incident: Theft of Resident and Employees Money Description of Incident: Please see Staff's Report. Facility's Intervention: Please see attached Staff's Report. Reported Incident to North Las Vegas Police Department for Investigation with case number 09-11325..."	F 226		

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F 226	Continued From page 45 A statement dated 5/13/09, attached to the self report (unable to determine the name and title of the employee (writer) of the statement) stated as follows: "(Resident #31) was admitted to our facility on July 10, 2008. When she was admitted she had all of her personal belonging including her wallet; which contained her bank card. On several occasions (Resident #31) misplaced her wallet and it was returned to the business office by an employee; (Resident #31) verified all fund and financial cards were in there. On or about the third time we gave her wallet back to her (Resident #31) and (Employee #15) spoke with (Resident #31) and (Resident #31) agreed to put her wallet in the company safe for safekeeping... (Resident #31) authorized (Employee #17) to give (Employee #4) her (Resident #31) debit card. (Resident #31) gave (Employee #4) the pin number to the debit card. On November 18, 2008 (Employee #4) removed $800 from (Resident #31's) Well's Fargo Bank account via the ATM (Automatic Teller Machine) on November 19, (Employee #4) removed $420 from (Resident #31's) Wells Fargo Bank account via the ATM both transactions were authorized by (Resident #31)...On Monday, May 11, 2009 at approximately 11:30 am, (Resident #31) went to the business office, room 502, where (Employee #16) and (Employee #15) were in from the doorway she blurted out '(Employee #4) stole my money. '...When (Resident #31) came in she said that (Employee #4) had her (Resident #31) debit card and was using it for herself (Employee #4). (Resident #31) stated that (Employee #4) told her (Resident #31) that there was $900 and something dollars in the account. (Resident #31) stated that she (Resident #31) just got off the phone with Well's Fargo Bank and there was only	F 226		

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$46. (Resident #31) explained that (Employee #4) had her (Resident #31) debit card from a transaction in November 2008 regarding Social Security...Upon our information and belief (Employee #4) and (Resident #31) went to the bank without anyone's knowledge and pulled out $800...(Employee #4) and (Resident #31) came back from the bank they both went to (Employee #16's) office to give the cash to her for deposit into the trust..."

According to the statement, two deposits were made on 5/11/09 (12:59 PM and 1:11 PM, deposit amounts unknown), and one withdrawal was completed at 1:54 PM. There was no clear indication in the written statement or in the resident's file regarding the discrepancy of the money withdrawn by Employee #4 (documented as a total of $1,220.00 (11/18/08)) and the remaining balance in the resident's account on 5/11/09.

On the afternoon of 9/3/09, interview with the Administrator and the Business Office Manager (Employee #16) regarding the misappropriation of resident's funds. The Administrator verified the facility did not follow up to obtain a copy of the police report regarding the North Las Vegas Police Department's investigation.

The facility failed to prevent and subsequently identify the misappropriation of one resident's funds by a facility employee.

As indicated above, the facility did not meet their policy and regulatory requirements by NOT:
a) Sensitizing staff (adeqaute training) to recognize misappropriation practices;
b) Identifying ongoing misappropriation practices;

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F 226	Continued From page 47 c) Taking adequate measures to prevent and/or mitigate misappropriation practices; d) Conducting sufficient investigations when misappropriation practices occur, or allege to occur, to properly establish the validity of the existance of misappropriation practices; [Resident #32] [and Employee #10] Resident #32 was admitted 10/7/08, with diagnoses including Diabetes Mellitus Type II, Neuropathy in Diabetes, Hypertension, Depressive Disorder, Anxiety State, Edema, Hyperlipidemia, Chronic Pain, Psychosis, Convulsions, and Constipation. The facility submitted a report 7/12/09, via facsimile regarding an allegation of physical abuse by a staff member toward Resident #32, which stated: "Date of Incident: July 21, 2009. Person Involved: (Resident #32). Type of Incident: Allegations of Physical Abuse. Description of Incident: Please see attached reports from the Social Worker, License-Nurse and Unit Manager. Facility's Intervention: Assessment done...skin remain (sic) intact, no redness nor bruises noted. CNA was transferred to another hall. Care Planned... Conclusion: Unsubstantiated R/T (Related To) no witness on allegation. CNA was transferred to another hall. The Social Worker's written statement dated 7/21/09 stated, "Resident (#32), Room (#) reported that she placed her juice on the bottom	F 226		

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of the medication cart. The nurse accidentally spilled Resident (#32's) juice on the floor. (Employee #10) went to pick up towel to wipe the spill. While wiping the spill, CNA (Employee #10) was allegedly pointing his finger to Resident (#32) and telling her that 'you spill things everywhere and have someone does your cleaning up. Resident (#32) reported that CNA (Employee #10) allegedly grabbed her arm, therefore he and hit him on his chest. CNA (Employee #10) was interviewed this morning regarding the incident. CNA (Employee #10) reported that when the Nurse was dispensing medications, she accidentally spilled a cup of juice that was placed under the medication cart by Resident (#32). CNA (Employee #10) went to get a towel to wipe the spill and told Resident (#32), 'that's why you're not supposed to put anything on the medication cart. ' CNA (Employee #10) reported that Resident (#32) hit him on the chest. There were two staff that witnessed the incident. Their statements are attached. CNA (Employee #10) was transferred to another hall."

Based on record review and confirmed by interview with the Social Worker (Employee #3), the Administrator, and the DON on the afternoon of 9/3/09, the facility did not interview any other residents regarding whether they had witnessed or been physically abused by Employee #10 (employed 5/6/03).

As indicated above, the facility did not meet their policy and regulatory requirements by NOT:
a) Identifying ongoing abusive practices;
b) Taking adequate measures to prevent and/or mitigate abusive practices;
c) Conducting sufficient investigations when abusive practices occur, or allege to occur, to

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F 226	Continued From page 49 properly establish the validity of the existance of abusive practices; Review of personnel files on 9/9/09 and 9/10/09 and verified by interview with the Administrator on 9/10/09, the following employee files lacked evidence of appropriate screening (background check results) and training: Employee #3 was employed as a Social Worker 6/1/07. There was no documentation of the results of a FBI (Federal Bureau of Investigation) background check. Employee #8 was employed as a CNA 6/29/09. There was no documentation of a copy of the employee's fingerprints and evidence that they were forwarded to the Nevada State Repository. There was no documentation of a background check. Employee #10 was employed as a nurse consultant. (There was no documentation regarding Employee #10's date of employment; however, it was verified by interview with the Administrator that Employee #10 conducted training for the prevention of abuse and neglect in January, 2009.). There was no documentation of the results of a background check. As indicated above, the facility did not meet their policy and regulatory requirements by NOT: a) Adequately screen staff for employment Surveyor: 26907 Resident #28 [and Resident #27]	F 226		

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Resident # 28 was a 65 year old female admitted to the facility on 7/15/09, with diagnoses including Paranoid Schizophrenia, Alzheimer's Disease, and Insomnia.

Documentation in the nurse's notes indicated Resident # 28 was pleasant, alert and cooperative with short term memory loss. Resident #28 had a psychiatric history, but no documentation of sexually inappropriate behavior.

Resident #27 was a 68 year old male admitted to the facility on 7/20/09, with diagnoses including Bipolar Disorder, Delusional Disorder, Dementia, and Hypertension.

The Mission Pines Referral Form, dated 7/14/09, submitted by North Vista Hospital prior to Resident # 27's admission indicated:
- "Sent out for Legal 2000 R/T (related to) inappropriate sexual behavior.
- Has inappropriate sexual response."

The admission care plan for Resident #27, dated 7/20/09, did not address the resident's psychiatric or sexual history. There was no intervention to include frequent monitoring or observations of the resident's behavior with other residents.

The Interdisciplinary Care Conference notes dated 8/4/09, did not address Resident #27's psychiatric and sexual history.

The initial MDS (Minimum Data Set) indicated Resident #27 had no history of Mental Illness.

Resident #27's Care Plan dated 7/31/09 did not address the resident's psychiatric or sexual history.

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F 226	Continued From page 51 On 8/8/09, Resident #27 was found in Resident #28's room engaging in inappropriate sexual behavior. On 9/10/09 at 10:45 AM, the Unit Manager indicated when a resident was admitted to the facility, they were monitored closely to assist with the transition to a new facility. There were no specific intervals established to monitor new residents. When a resident had been identified with an inappropriate sexual history, the resident would be placed closer to the nurse's station and monitored every 15 - 30 minutes. On 9/10/09, the Unit Manager indicated Resident # 28 had never been observed acting inappropriately with other residents. The Unit Manager added, on 8/8/09, Resident #28 was observed by staff holding Resident #27's hand and walking through the 200 Hallway. On 9/10/09 at 1:30 PM, the MDS Coordinator indicated when completing the MDS, she does not review the medical and psychiatric history. Therefore, this was not picked up and did not trigger a RAP (Resident Assessment Protocol). She indicated the charge nurse completed the initial care plan As indicated above, the facility did not meet their policy and regulatory requirements by NOT: a) Sensitizing staff (adeqaute training) to recognize abusive practices; b) Identifying abusive practices; c) Taking adequate measures to prevent and/or mitigate abusive practices; d) Conducting sufficient investigations when abusive practices occur, or allege to occur, to	F 226		

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F 226	Continued From page 52 properly establish the validity of the existance of abusive practices;	F 226		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 21794 Based on observation, interview, and record review, the facility failed to ensure an environment that maintains residents' dignity and respect. Findings include: Observations: On 9/2/09 at approximately 2:00 PM, three female staff members were speaking in a foreign language while sitting in the resident's small dayroom area. At the time of the observation, there were five residents within the immediate area of the staff members. Interview: During a resident group interview conducted on 9/2/09 at 10:00 AM, several residents who attended the meeting were asked about communication between staff members. The majority of the resident attendees acknowledged that they have observed staff members speaking in foreign languages in their presence. Surveyor: 26907	F 241		

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F 241	Continued From page 53 Resident #20 Resident #20 was a 51 year old female admitted to the facility on 11/20/07, with diagnoses including Malignant Neoplasm of the Bronchus, Depressive Disorder, Hypertension and Edema. On 9/1/09 in the afternoon, Resident #20 was observed sitting at the dining table in the 200 Hall playing BINGO with the other residents of the unit. The nursing and activities staff were observed in the area monitoring the residents. Resident #20's attending physician came to the 200 Hall and examined Resident #20 while she remained at the table. The physician auscultated Resident #20's lungs and checked the resident's ankles for edema. The physician did not request Resident #20 return to her room. The staff did not offer to take Resident #20 back to her room to maintain the resident's privacy. On 9/2/09, the Unit Manager acknowledged she had seen the physician examine Resident #20 at the Dining Table the day before. She indicated the physician sometimes forgets to ensure the residents are seen and examined in their room to maintain privacy. Surveyor: 27178 Resident #41 Resident #41 was a 75 year old female admitted on 7/17/09, with diagnoses including Dementia, Depressive Disorder, Hypertension, Hyperlipidemia and Hypothyroidism. On 9/3/09 in the morning, Resident #41 revealed, prior to admission, she enjoyed going out with	F 241		

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friends and enjoyed outdoor activities. Resident #41 further revealed, "Since I got here, I haven't gone outside. I would love to go out and feel the sun. I don't understand why I need to be inside all the time when the smokers can at least go out on the patio. Sometimes, I ask myself, do I need to start smoking to be able to go out?"

Resident #41 pulled out a couple of coloring books from the bedside drawer stated,"This is what they want me to do. My grandchildren don't even do coloring books and they want me to do this? An old woman doing coloring books?"

Resident #41 further revealed, "One time, I told one of the staff that I'd do anything to leave this place. I said that because I was frustrated. That nurse told someone that I was going to abandon this place without their knowledge. How could I do that? My husband is here. We live here now. All I want is to be able to go out once in a while and enjoy the sun and be able to just sit outside. Because of that incident, they put this (wander guard on the wrist) on me so I won't be able to go out. I already talked with the staff about this but I was told I can't go out of the facility even out there on the patio because I might leave without their permission; I feel like a prisoner."

During the interview with Resident #41, it was observed that Resident #41's husband/room mate was non-ambulatory who required 2 person assistance in transferring him from a wheelchair to his bed with the use of a Hoyer lift.

The Physician's Progress Notes dated 7/20/09 indicated, Resident #41 was admitted from home.

An Elopement Assessment form was completed

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on 7/17/09 indicating, Resident #41 had Alzheimer's Disease and Dementia, and Resident #41 had a past history of elopement from home or the facility.

An Informed Consent for Use of Restraints was signed by Resident #41's daughter on 7/17/09. The consent revealed the use of the Wander Guard was recommended for the purpose of "enabler".

A Fall Risk Assessment dated 7/17/09 revealed, Resident #41 was alert and oriented x3 (people, place, and time).

The Nurses Notes dated 7/17/09 at 12:00 revealed, Resident #41 was admitted to the facility, alert and oriented x 2 with confusion. An order for the use of wander guard was received from the physician upon Resident #41's admission to the facility.

The Nurses Notes dated 7/21/09 revealed, Resident #41 was alert and oriented x 3 with confusion. Resident #41 ambulated around the hall and was adjusting well to new environment.

The Nurses Notes dated 8/29/09 revealed, Resident #41 apparently verbalized to a nurse that, "will get out of the facility together with her husband who are room mates, that they will never come back anymore."

A Safety Monitoring Sheet was completed on 8/29/09 to 8/31/09. The monitoring tool lacked indication Resident #41 had attempted to leave the facility.

The Minimum Data Set dated 7/29/09 revealed,

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Resident did not exhibit wandering within the seven day look back.

On 9/3/09 at 11:10 AM, Employee #22 revealed, "I am not aware of any attempts that (Resident #41) tried to leave the facility. I asked before why she couldn't go out on the patio because I know how much she loved being outside, before she was admitted here. I was told, she couldn't go out because she has a Wander Guard."

On 9/3/09 at 1:30 PM, Employee #7 revealed, "Employee #41 has a wander guard on. I was told by Nursing she can't go out. I don't really know the rationale for that. She seems to be with it and she's ambulatory. And even if she's a little confused, she could join us. I have a group of residents who go out on the patio supervised, just to break the routine of being inside all the time. I'm sure she would like that. I know she enjoyed the outdoors that's why I gave her a plant in her room. At least, she could do a little gardening."

Employee #7 further revealed, "I am not aware of any incidents of elopement or any attempts made by (Resident #41)."

On 9/3/09 at 2:00 PM, Employee #21 revealed, "I didn't know that the Wander Guard was ordered on the day she was admitted. The Wander Guard is used for residents' safety. It's for residents who are confused and wanders around the facility. It's to keep the confused residents from leaving the facility. The use of Wander Guard should have been re-assessed and evaluated by the Unit Manager after 30 days."

Employee #21 further revealed, "I don't know of any attempts that (Resident #41) tried to escape.

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F 241	Continued From page 57 But the Wander Guard is for (Resident #41) 's safety so she can't go out." On 9/3/09 in the afternoon, the Director of Nurses (DON) revealed, Resident #41 was a wanderer who was assessed to be at "high risk for elopement." The DON was unable to produce a copy of the assessment for Resident #41 which placed the resident at high risk for elopement. The DON was unable to provide any documentation to support Resident #41 had history of elopement and/or had attempted to elope from home and/or from the facility.	F 241		
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Surveyor: 26907 Based on observation, interview and record review, the facility failed to accommodate the individual needs of residents for 3 of 32 residents (Resident #19, #4, #13). Findings include: Resident #19	F 246		

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Resident #19 was a 55 year old female admitted to the facility on 8/10/09, with diagnoses including Brain Injury, Dementia, Delusional Disorder and Chronic Pain. Resident. The nurse ' s notes indicated the resident was Spanish speaking with limited English.

Resident #19's care plan dated 8/21/09, identified the problem - Memory impaired and included the following approaches:
- Keep clock, calendar and activity schedule in room.
- Establish a communication system: gestures, communication board, pictures, etc.

On 9/1/09 and throughout the survey, there was no clock, calendar, activity calendar or communication board seen in the room.

On 9/4/09, the Charge Nurse (CN) indicated Resident #19 was Spanish speaking but could understand some English. The CN added the staff use short sentences to try to communicate in English. According to the CN, occasionally the staff thinks Resident #19 understands what they are trying to say, but in reality, the resident did not. The CN gave the example of the staff asking Resident #19 if she wanted to return to bed. Resident #19 responded "yes". When the staff placed Resident #19 back in bed, the resident indicated "No, No, No." The staff then got Resident #19 back out of bed.

The CN indicated she had never seen a communication board used with Resident # 19. She indicated the staff had difficulty communicating with Resident #19 and believed a communication board, in Spanish and with pictures, would be helpful.

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The facility policy titled, "Guidelines for Communicating with Non-English Speaking or Aphagia," undated indicated:

"Purpose: To provide adequate communication with residents who (sic) non-English speaking or suffer from expressive aphggia (sic)."

Practices:
-"...3. A communication Board translated into the language of the resident."
Surveyor: 12211

Resident #4

Resident #4 was admitted 7/13/09, and readmitted 8/10/09, with diagnoses including Anorexia, Renal Dialysis, Congestive Heart Failure, End Stage Renal Disease, Diabetes Mellitus Type II, Anemia, Nausea with vomiting, Depressive Disorder, Anxiety state, Gout, Hypertension, and Failure to Thrive.

On 9/2/09 in the afternoon, Resident #4 was observed in his room sitting in his wheelchair. The resident's spouse (also a resident at the facility) was observed struggling while attempting to equip a foot rest to Resident #4's wheelchair, while the CNA was searching for the second foot rest inside the room. It was confirmed with the CNA later that afternoon that Resident #4 does need both foot rests to avoid dragging his feet on the floor while being wheeled. The CNA further indicated that the other foot rest was not able to be located. On 9/2/09 and 9/3/09, Resident #4 was observed leaning his head forward and to the side while sitting in his wheelchair.

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F 246	Continued From page 60 The facility did not ensure Resident #4 was accommodated with head support and foot rests for positioning. Resident #13 Resident #13 was a 56 year old female admitted 3/21/08, with diagnoses including Convulsions, Dementia, Esophageal Reflux, Acute Peptic Ulcer, Depressive Disorder, Symbolic Dysfunction, Abnormality of Gait, Mental Disorder, Nutrition Deficiency, and Prophylactic Measure. On 9/1/09 and 9/2/09, Resident #13 was positioned with her head tilted along a table surface near the nurse's station. There was no cushion or support for her head. The facility did not accommodate Resident #13 with head support.	F 246		
F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Surveyor: 21794 Based on observations, the facility failed to ensure a safe, clean, comfortable and homelike environment was provided for all residents in 3 of 4 inhabited Units (#200, #300, #600). Findings include: Observations:	F 252		

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F 252	Continued From page 61 600 Unit Resident Room #603 1. Wall between the resident shower and toilet had broken down at the base of the wall and floor. 2. The bathroom wall contained holes and the toilet paper dispenser was broken. 3. The toilet paper dispenser was broken. Resident Room #613 had the following problems: 1. The paper towel dispenser was falling off the wall. 2. A broken bedside table (top drawer). 3. Wall between the resident shower and toilet had broken down at the base of the wall and floor. The baseboard was falling off the wall. Resident Room #620 had the following problems: 1. Cabinet with sink in the room was missing a front door and broken pieces of wood were laying inside the cabinet. 2. A broken towel rack, with broken pieces of the hardware still attached to the cabinet. 3. Wall between the resident shower and toilet had broken down at the base of the wall and floor. The baseboard was falling off the wall. Resident Room #601 had the following problems: 1. Paint was peeling from walls and ceiling. 2. There were holes in the ceiling. 3. Cabinet with sink in the room appeared to have the front door replaced, but the doors were white and not the color of the darker cabinet. Resident Room #614 had the following problems: 1. Wall between the resident shower and toilet had broken down at the base of the wall and floor. The baseboard was also falling off due to water	F 252		

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F 252	Continued From page 62 damage. 2. There were holes in the bathroom walls. 3. Shower curtain was missing. Resident Room #610 had the following problems: 1. The vent cover was missing on the ceiling of the bathroom. 2. There were screws sticking out of the walls in the bathroom. 3. Cabinet with sink in the room appeared to have the front door replaced, but the doors were white and not the color of the darker cabinet. Surveyor: 26907 200 Unit Resident Room #202 had the following problems: 1. A 4" (inch) hole in the door to the bathroom 2. The base of the sink vanity was missing half of the molding and was deteriorating. 3. The blinds were missing approximately 9 slats. The room was visible from the outside. 4. Molding was hanging off near the shower. 5. Rust/mold on the window sill in the shower. Resident Room #206 had the following problems: 1. A 5" hole in the bathroom door and had spackle in the hole, which was now peeling and falling off. 2. The bathroom had 6 tiles that had fallen off the wall in the shower, 3 additional tiles were lying on the floor in the shower. Resident Room #205 had the following problems: 1. A large hole in the wall by the window 2. The headboard was leaning forward and was easily moved back and forth. 3. The shower had tiles missing at the entry to the shower.	F 252		

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Resident Room #203 had the following problems:
1. The bathroom had a very foul sewer smell.
2. The floor tiles were falling off the wall in the area surrounding the toilet and at the entrance to the shower.
Surveyor: 27178

300 Unit

Resident Room # 301 had the following problems:
1. A broken sink counter top; and
2. A missing window screen.

Resident Room #303 had the following problems:
1. Big paint chipped from wall panel;
2. Missing baseboard by the bathroom door;
3. Sink counter top coming off;
4. Holes to bathroom door; and
5. Wall tiles missing in the shower stall

Resident Room #304 had the following problems:
1. Broken/cracked tiles in the shower stall.

Resident Room #305 had the following problems:
1. Dried feces all over the bathroom floor.

Resident Room #311 had the following problems:
1. Baseboard missing in the bathroom upon entry from Room #313.

Resident Room #314 had the following problems:
1. Missing wall tiles in shower room; and
2. Bathroom door with a hole.

Resident Room #315 had the following problems:
1. Missing door below the sink

Resident Room #318 had the following problems:

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F 252	Continued From page 64 1. Toilet bowl with big black stain up to the water level; 2. Missing wall tiles in the shower room; 3. Bathroom ceiling with a hole around the light fixture; 4. Window blinds with missing slats; and 5. Baseboard coming off around the sink area. Resident Room #320 had the following problems: 1. Window blinds with missing slats.	F 252		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 21794 Based on record review and interview, the facility	F 279		

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failed to ensure careplans were properly reviewed, developed and/or revised for 3 of 34 residents (#33, #27, #26).

Findings include:

Resident #33

Resident #33 was a closed record review. This resident was an 83 year-old male admitted to the facility on 6/10/09, and discharged on 8/3/09, with diagnoses including Delusional Disorder, Episodic Mood Disorder, Dementia, Chronic Ischemic Heart Disease, Hypertension, Diabetes Mellitus, Congestive Heart Failure Not Otherwise Specified, Chronic Kidney Disease Not Otherwise Specified and Pure Hypercholesterolemia.

Record review:

The Discharge Summary from North Vista Hospital, dated 6/10/09, indicated one of the documented reasons for admission to the hospital was due to "inappropriate sexual behaviors." At the time of discharge, the resident's mental status examination indicated, "Patient is not having sexual preoccupations or aggressive behaviors."

Dr. (Physician's Name)'s Admission History and Physical, dictated on 6/12/09, indicated in the fourth paragraph, "He has had behavior issues including inappropriate sexual behaviors."

The resident's initial plan of care, dated 6/10/09, revealed no documented evidence that the resident's history of inappropriate sexual behaviors was specifically addressed. The initial plan did indicate that the resident was to be on psychotropic medications with monitoring of any

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F 279	Continued From page 66 possible medication induced side effects. Further review of the record did provide evidence that the facility was monitoring sexually inappropriate behavior and the resident's resistance of care, however, the medication record flow sheet was not accurate to or in coordination with reported accounts of the resident's inappropriate sexual behaviors. Two days following admission the resident was displaying aggressive, inappropriate sexual behaviors directed towards others. It was indicated in a Nurse's Note, dated 6/12/09 at 2200 (10:00 PM), "Res. (resident) noted to reach out and grab female res. and staff on the chest area in a sexual manner." In a Nurse's Note, dated 6/15/09 at 0600 (6:00 AM), "Continues to makes gestures with his hands encouraging them to come closer. Monitored for inappropriate sexual advances to female residents." At 0830 (8:30 AM) on 6/15/09, in the Nurse's Notes, "Following behind residents attempting to touch them." The inappropriate sexual behaviors displayed by the resident and actually observed by staff (on 6/12/09 and two separate events on 6/15/09) were not documented in the resident's Medication Administration Record (MAR) as required to assist in monitoring the resident's Anti-Psychotic medication (Risperdal and Seroquel). Additional entries in the Nurse's Notes revealed the resident continued to display inappropriate sexual behaviors. An entry on 6/18/09 at 2200,	F 279		

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noted that the resident was "sexually inappropriate to residents x (times) 1."

An entry in the Nurse's Notes on 6/19/09 at 2130 (9:30 PM), again revealed that the resident was sexually inappropriate with one female resident. The resident was apparently redirected successfully by staff as indicated in the entry.

A Social Service Progress Note, dated 6/21/09, indicated that staff have acknowledged the resident's inappropriate sexual behaviors and attempts to touch female staff breast and genitalia, but was redirectable. In the same note, the social worker indicated the resident was compliant with facility rules and care. However, there was no mention that this resident was sexually inappropriate with his female peers as evident by entries in the Nurse's Notes.

The first evidence of a care plan identifying the resident's inappropriate sexual behavior was dated 6/22/09. The Goal was noted as "Resident #1 (name) will exhibit socially inappropriate behavior no more than twice weekly through next review."

A Nurse's Notes entry on 7/1/09 at 1800 (6:00 PM), revealed that nursing staff received a TO (telephone order) from Dr. (Physician Name) for the resident to be seen by a Psychiatrist for Delusional Disorder.

An entry in the Pharmacist Progress Note/Medication Regime Review on 7/17/09, noted, "Resident is pending psychiatric eval. (evaluation) following recent Gero-psych (geriatric psychiatric) admit."

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Additional calls were placed to Dr (Physician Name) on 7/24/09 at 1700 (5:00 PM) and 7/27/09 at 1445 (2:45 PM), for a Psychiatric evaluation for the resident. The entry on 7/27/09 indicated, "Dr. (Physician Name) states psychiatric evaluation not needed d/t (due to) pt. (patient) stability at this time."

The facility's Telephone Orders dated 7/1/09, indicated the resident was okay to to be seen by the Psychiatrist. However, as indicated above, documentation in a Telephone Order on 7/27/09, indicated the resident was stable and no psychiatric evaluation was required at that time.

As indicated in a Nurse's Notes entry on 7/30/09 at 1700, the resident continued to display inappropriate sexual behaviors. It was noted that female residents indicated the resident was "flirting" with them.

On 7/31/09 at 11:00 AM, it was documented in a Nurse's Note, "Resident making foul nasty remarks to residents and to the lady staff members." It was indicated in the note that the resident was verbalizing explicit sexual acts towards residents. It was further indicated that staff would monitor resident to keep him away from the lady residents.

On 8/3/09 at 1200 (12:00 PM), it was indicated in the Nurse's Notes that the resident was to be transferred to 200 Unit (Alzheimer unit) for alleged sexual innuendos toward other residents. Staff indicated in the note that this behavior wasn't witnessed.

At 1500 (3:00 PM) on 8/3/09, another entry indicated that the resident continued to make

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inappropriate gestures and innuendos towards residents while sitting in the common area on the unit.

A 4:30 PM entry in the Nurse's Notes indicated the social worker received an order to "Legal 2000" the resident to North Vista Emergency room for admit to their Gero-Psych. Unit. Resident was transferred out by 5:45 PM on 8/3/09.

On 8/3/09, two entries were noted on the Physician Telephone Orders, the first was an order for a Psychiatric evaluation and the second order was to Legal 2000 the resident to North Vista Hospital.

Note: "Legal 2000" is a reference to the State of Nevada's legal competency process. It is being used here as a short-hand reference for the facility to transfer the resident to an acute care hospital's emergency department for psychiatric evaluation and legal adjudication.

The care plan generated on 6/22/09 had no evidence that it was updated following reports of additional inappropriateness by the resident. A Comprehensive Care Plan was generated on 8/3/09, following the final observations of sexual inappropriate behaviors and subsequent transfer from the facility.

A document maintained in the resident's record, dated 8/3/09, contained documented statements from four different residents (Resident #35, Resident #36, Resident #37, and Resident #38) and one female staff member. The four unsampled residents, Resident #35, Resident #36, Resident #37, and Resident #38

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acknowledged that the resident was sexually inappropriate.

It was noted in the 08/03/09 document that on 7/31/09, the resident went to Resident #35's table in the dining room and grabbed her arm and was trying to touch her shirt. During the interview with Resident #37, he indicated that Resident #33 was touching Resident #35's breast and when he saw staff stopped.

It was further noted in the document that the resident had touched the leg of Resident #36 and made inappropriate sexual comments to her on 7/31/09. Resident #38 was noted to say that she hadn't witnessed anything on 7/31/09, but acknowledged that the resident makes inappropriate sexual comments to her and other females.

The above aforementioned document, dated 8/3/09, was the first evidence of a facility investigation or reporting of the resident's ongoing behavior. The final report was completed on 8/6/09. The investigation only covered the event of sexual inappropriateness on 7/31/09.

Interview:

On 9/10/09, the Director of Nursing was interviewed and asked if additional documentation, reports or investigations were available for review concerning this resident's behaviors. The Director of Nursing acknowledged that there were no other care plans or evidence of follow-up available.
Surveyor: 26907

Resident #27

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Resident #27 was a 68 year old male admitted to the facility on 7/20/09, with a diagnosis including Bipolar Disorder, Delusional Disorder, Dementia, and Hypertension.

The Mission Pines Referral Form dated 7/14/09, submitted by North Vista Hospital prior to Resident # 27's admission indicated:
- "Sent out for Legal 2000 R/T (related to) inappropriate sexual behavior.
- Has inappropriate sexual response."

The admission care plan for Resident #27, dated 7/20/09, did not address the resident's psychiatric or sexual history. There was no intervention to include frequent monitoring or observations of the resident's behavior with other residents.

The Interdisciplary Care Conference notes dated 8/4/09, did not address Resident #27's psychiatric and sexual history.

The initial MDS (Minimum Data Set) indicated Resident #27 had no history of Mental Illness.

Resident #27's Care Plan dated 7/31/09, did not address the resident's psychiatric or sexual history.

On 8/8/09, Resident #27 was found in Resident #28's room engaging in inappropriate sexual behavior.

On 9/10/09 at 10:45 AM, the Unit Manager indicated when a resident was admitted to the facility, they were monitored closely to assist with the transition to a new facility. There were no specific intervals established to monitor new

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residents. When a resident had been identified with an inappropriate sexual history, the resident would be placed closer to the nurse's station and monitored every 15 - 30 minutes.

On 9/10/09 at 1:30 PM, the MDS Coordinator indicated when completing the MDS, she does not review the medical and psychiatric history. Therefore, this was not picked up and did not trigger a RAP (Resident Assessment Protocol). She indicated the charge nurse completed the initial care plan.
Surveyor: 27178

Resident #26

Resident #26 was a 55 year old male admitted on 12/23/08, with diagnoses including Depressive Disorder, Anemia, Hypertension, Dementia, Chronic Ischemic Heart Disease and End Stage Renal Disease.

Resident #26 was transferred to an acute care hospital emergency department for evaluation and appropriate placement on 9/5/09.

The Social Service Quarterly Progress Notes dated 6/9/09 revealed, Resident #26 sometimes would get agitated and aggravated by peers and would "yell and curse them and sometimes hit them or attempt to hit them."

The Minimum Data Set dated 6/10/09 revealed, Resident #26 had verbally abusive behavioral symptoms and physically abusive behavioral symptoms.

The Comprehensive Plan of Care review revealed:

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- An initial care plan regarding Resident #26's Episodes of Unwanted Behaviors: Resident sexually inappropriate with staff and residents was dated 9/5/09;
- A Temporary Care Plan dated 6/19/09, was completed regarding an altercation incident with another resident on 6/18/09; and
- There were no other care plans written addressing Resident #26's inappropriate behavior.

The Activity's Annual Progress Notes dated 9/3/09, written by Employee #13 revealed, Resident #26's behavior during ongoing programs has disrupted and agitated other peers. Resident #26 would fondle female peers especially female peers that were physically challenged.

Social Service Progress Notes dated 9/5/09 revealed, Employee #13 had reported Resident #26 would attempt to touch, fondle or kiss any female residents especially those who were physically challenged. Employee #13 would remove the residents away from Resident #26. Resident #26's behavior had been a continued behavior for several months. Resident #26 was witnessed by the Social Worker on 9/5/09, that while Resident #26 was being showered, Resident #26 attempted to grope the CNA. Employee #13 attempted to talk with Resident #26's inappropriate behavior, but Resident #26 started blowing kisses at her.

On 9/10/09 at 2:30 PM, a meeting with the Administrator, Director of Nurses (DON) and Social Worker revealed the following:

The Social Worker revealed, Resident #26 was friendly who liked touching other people, giving

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F 279	Continued From page 74 hugs and giving kisses, may it be by blowing kisses or gesturing to kiss. The Social Worker further revealed, Resident #26 would openly extend his arms to ask for hugs and/or to reach anyone close to him. The Social Worker further revealed, the Social Services Quarterly Notes dated on 6/9/09, was written by a part-time Social Worker. The Social Worker stated, "I don't know where she (part-time Social Worker) got her information from. I didn't read her notes." The Social Worker revealed, she was not aware of Resident #26's inappropriate behaviors until 9/5/09. This was when the Social Worker witnessed Resident #26 tried to grope the CNA while Resident #26 was being showered. This incident prompted the Social Worker to contact Resident #26's primary physician, who in turn ordered for Resident #26 to be transferred to an acute hospital emergency room for evaluation and appropriate placement. The Administrator revealed, a care plan was initiated sometime in June 2009 addressing Resident #26's inappropriate sexual behaviors. The Administrator further revealed, the Charge Nurses initiated the care plans. The information from the other Social Worker (part time Social Worker) regarding "cursing and hitting other residents could have been from many years ago." The DON was unable to find or provide a copy of the care plan written in June 2009 addressing the Resident #26's inappropriate behaviors.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must	F 309		

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F 309	Continued From page 75 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 21794 Based on record review and interview, the facility failed to ensure physician orders were followed for 2 of 34 residents. (#18, #23) Findings include: Resident #18 Resident #18 was a 68 year-old female admitted to the facility on 4/24/09, with diagnoses including Diabetes Mellitus Type II, Hypertension, Depression and Selective Nutrition. Record review: A Physician Telephone Order dated 7/7/09, noted an order for "weekly wts. (weight measuring) r/t (related to) wt. loss." A Physician Telephone Order dated 7/15/09, was a clarification order and noted, "Weekly wts. if wt. loss x (times) 4 wks (weeks). Documentation on the resident's weight record revealed that the last weight in July 2009 was noted on 7/6/09, with 8/6/09 as the next documented weight. There was no documented evidence the resident had been weighed during	F 309		

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this one month interval with recorded weights.

Further review of the weight record revealed the resident had lost weight during this period, however documentation in the nutrition notes had consistently indicated the resident's weight loss was desired due to her initial weight of 216 pounds (lbs), which calculated to over 176% over her ideal body weight.

The weight record revealed a loss of 5.8 lbs during the period between 7/6/09 and 8/6/09, which was not significant, however desired weight loss had been reinforced through numerous notes documented by the dietary department.

Interview:

On 9/9/09 at 2:00 PM, Resident #18 indicated during an individual interview that her desire was to reach 150 lbs. She acknowledged that she enjoys the food here at the facility but controls her portions.

Resident was aware of the facility's various orders of supplements and concern with the weight loss being too rapid and accepts the attention.

On 9/9/09 at 9:25 AM, the Director of Dietary indicated that she was aware of Resident #18's desire to lose weight and acknowledged that supplements and other concerns were to control a weight loss that was rapid.
Surveyor: 26907

Resident #23

Resident #23 was a 66 year old male originally admitted to the facility on 8/20/03, and

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readmitted on 12/21/08 and 3/16/09, with diagnoses including Malignant neoplasm of the Brain, Dementia, Diabetes and Hypertension.

Resident #23's Readmission Nutrition Assessment by the dietician dated 1/7/09 indicated, "...Weight loss trend with significant change of 13% x 180 days.... Recommend NEM (Nutritionally Enhanced Meal) program. Will cont (continue) to mtr (monitor) through Nutr. (Nutrition)/Hydration committee."

Dietary Progress notes written by the dietician dated 1/22/09 revealed, "...Meal observation done- RT (Resident) with noticeable oral dysphagia- unable to chew even lasagna. No teeth in place. Dx (Diagnosis) Involuntary weight loss r/t (related to) unable to masticate solid/semi-solid texture...Wt loss down 7% in 3 weeks...Change diet to RCS Puree - DC (discontinue) NAS (No added Salt) to enhance taste sensation...Cont weekly weights until stable. Await ST (Speech Therapy) evaluation to rule out underlying pharyngeal dysphagia."

The documentation by the Nutrition/Hydration Committee revealed the following:
-1/28/09 "...Rt reviewed for wt loss & (and) p/u (pressure ulcer) to L (left) buttock. Blister now open. Vit (vitamin) TX (therapy) in place...CBW (calculated body weight) down 11 # (pounds) or 7% in 2 weeks...Receiving puree, RCS diet with NEM program & fortified whole milk tid (three times a day) with meals. N/O (new order) for Megace & ST eval (speech therapy evaluation). Rt fed by staff...."

- 2/4/09 "...Wt 146.8. Rt noted with Wt loss down 9/7 # or 6.1% x 30 days for significant change,

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however wt stabilizing after 2 weeks...ST (speech therapy) results pending. Recommend weekly weights x4 to monitor..."

2/25/09 "...No new weight. Dietary interventions in place. Will cont to mtr & f/u. Recom - RA (Resident Assist) dining sec (secondary) to weight loss of 17% x 180 days.

3/18/09 "...CBW 141.8 # readmit weight. Previous weight down 28.8 # or 16.6% x 90 days...New diet of puree RCS with Honey thick liquid. fed by staff. NEM program& FF milk ongoing..."

The Physician's orders revealed the following:
- 1/22/09 S/T eval (evaluation) & treatment r/t (related to) weight loss
- 2/4/09 Weekly weights x 4 to monitor for secondary to recent weight loss

The speech therapy evaluation form dated 1/27/09 documented:
- Diagnosis: Dysphagia
- Short term goals : 1) oral motor exercises; 2. Diet alterations as tolerated.
- Frequency (times weekly): 2; Duration: 4 weeks

The ST Treatment grid documented Resident #23 was seen by ST on 1/29/09, 2/3/09, and 2/5/09 for 45 minutes each time.

There was no documentation by the ST that Resident #23 was seen and treated beyond 2/5/09.

A form titled, "All Care Home Health Physician Summary" dated 2/9/09, for Speech therapy services indicated:
"-At the time of discharge, our goals were not

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met."
- The reason for discharge indicated D/C (Discontinue) per Dr.(Doctor) Order.

There was no discharge order written by the physician to discontinue Speech therapy services.

The weight record dated 2009 documented Resident #23's weight as below:

Jan 1 156.5
Jan 6 155.3
Jan 8 149.8
Jan 15 145.5
Jan 15 145.5
Jan 29 146
Feb 3 146.1
Feb 3 146.8
Mar 3 145.2
Mar 3 146
Mar 18 141.8
Mar 19 142.8
Mar 26 131.2
Mar 26 131.2

There was no documented evidence that Resident #23 had weekly weights done in February 2009, as ordered by the physician and recommended by the dietician.

There was no documentation Resident #23 was weighed on the week of 3/10/09. (Resident #23 was in the acute care facility from 3/11/09 - 3/16/09.)

Documentation on Resident #23's Dietary intake form revealed the resident's intake was not documented consistently for the months of January through March 2009. Review of the

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F 309	Continued From page 80 intake forms revealed: January 2009 No documentation of meal intake for the following dates: 1/1, 1/4 - Dinner; 1/6/09 Breakfast & Lunch; 1/7/09 - Lunch; 1/11 - Dinner; 1/15 - All meals; 1/16 - Dinner; 1/17 - Lunch & Dinner; 1/18 - all day. 1/21. 22, 28,29 - Breakfast & Lunch. February 2009 No documentation of meal intake for the following dates: 2/11, 2/12, 2/18, 2/19, 2/24, 2/25 - Breakfast and Lunch March 2009 No documentation of meal intake for the following dates: 3/18, 3/20 - All meals; 3/19 - Dinner. There was no documented evidence on the meal intake form or in the progress notes that Resident #23 had difficulty chewing as documented by the Dietician on 1/22/09, during the meal observation. On 9/9/09 at 9:20 am, the Dietary Manager (DM) indicated she followed Resident #23 on the Weight Committee. The Weight Committee usually meets once a week on Wednesdays. The Weight Committee reviews the residents weight, evaluates the current therapy and makes recommendations for changes if indicated. The DM added that during February 2009, the Weight Committee did not meet. Therefore, Resident #23 was not followed and evaluated during that period.	F 309		

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F 309	Continued From page 81 The DM also acknowledged that weekly weights should have continued on Resident #23 due to the weight loss. The DM also confirmed the documentation of Resident #23's Dietary intake should have been more accurate.	F 309		
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Surveyor: 26907 Based on observation, interview and record review, the facility failed to ensure appropriate measures to maintain nutritional parameters to prevent resident's weight loss for 1 of 32 residents. (#23) Findings include: Resident #23 Resident #23 was a 66 year old male originally admitted to the facility on 8/20/03, and readmitted on 12/21/08 and 3/16/09, with diagnoses including Malignant neoplasm of the Brain, Dementia, Diabetes and Hypertension.	F 325		

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Resident #23's Readmission Nutrition Assessment by the dietician dated 1/7/09 indicated, "...Weight loss trend with significant change of 13% x 180 days.... Recommend NEM (Nutritionally Enhanced Meal) program. Will cont (continue) to mtr (monitor) through Nutr. (Nutrition)/Hydration committee."

Dietary Progress notes written by the dietician dated 1/22/09 revealed, "...Meal observation done- RT (Resident) with noticeable oral dysphagia- unable to chew even lasagna. No teeth in place. Dx (Diagnosis) Involuntary weight loss r/t (related to) unable to masticate solid/semi-solid texture...Wt loss down 7% in 3 weeks...Change diet to RCS Puree - DC (discontinue) NAS (No added Salt) to enhance taste sensation...Cont weekly weights until stable. Await ST (Speech Therapy) evaluation to rule out underlying pharyngeal dysphagia."

The documentation by the Nutrition/Hydration Committee revealed the following:
-1/28/09 "...Rt reviewed for wt loss & (and) p/u (pressure ulcer) to L (left) buttock. Blister now open. Vit (vitamin) TX (therapy) in place...CBW (calculated body weight) down 11 # (pounds) or 7% in 2 weeks...Receiving puree, RCS diet with NEM program & fortified whole milk tid (three times a day) with meals. n/o (new order) for Megace & ST eval (speech therapy evaluation). Rt fed by staff...."

- 2/4/09 "...Wt 146.8. Rt noted with Wt loss down 9/7 # or 6.1% x 30 days for significant change, however wt stabilizing after 2 weeks...ST (speech therapy) results pending. Recommend weekly weights x4 to monitor..."

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2/25/09 "...No new weight. Dietary interventions in place. Will cont to mtr & f/u. Recom - RA (Resident Assist) dining sec (secondary) to weight loss of 17% x 180 days.

3/18/09 "...CBW 141.8 # readmit weight. Previous weight down 28.8 # or 16.6% x 90 days...New diet of puree RCS with Honey thick liquid. fed by staff. NEM program& FF milk ongoing..."

The Physician's orders revealed the following:
- 1/22/09 S/T eval (evaluation) & treatment r/t (related to) weight loss
- 2/4/09 Weekly weights x 4 to monitor for secondary to recent weight loss

The speech therapy evaluation form dated 1/27/09 documented:
- Diagnosis: Dysphagia
- Short term goals : 1) oral motor exercises; 2. Diet alterations as tolerated.
- Frequency (times weekly) 2 Duration 4 weeks

The ST Treatment grid documented Resident #23 was seen by ST on 1/29/09, 2/3/09 & 2/5/09 for 45 minutes each time.

There was no documentation by the ST that Resident #23 was seen and treated beyond 2/5/09.

A form titled, "All Care Home Health Physician Summary" dated 2/9/09, for Speech therapy services indicated:
-At the time of discharge, our goals were Not met.
- The reason for discharge indicated D/C (Discontinue) per Dr.(Doctor) Order.

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There was no discharge order written by the physician to discontinue Speech therapy services.

The weight record dated 2009 documented Resident #23's weight as below:

Jan 1 156.5
Jan 6 155.3
Jan 8 149.8
Jan 15 145.5
Jan 15 145.5
Jan 29 146
Feb 3 146.1
Feb 3 146.8
Mar 3 145.2
Mar 3 146
Mar 18 141.8
Mar 19 142.8
Mar 26 131.2
Mar 26 131.2

There was no documented evidence that Resident #23 had weekly weights done in February 2009, as ordered by the physician and recommended by the dietician.

There was no documentation Resident #23 was weighed on 3/10/09. (Resident #23 was in the acute care facility from 3/11/09 - 3/16/09.)

Documentation on Resident #23's Dietary intake form revealed the resident's intake was not documented consistently for the months of January through March 2009. Review of the intake forms revealed:

January 2009
No documentation of meal intake for the following

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F 325	Continued From page 85 dates: 1/1, 1/4 - Dinner; 1/6/09 Breakfast & Lunch; 1/7/09 - Lunch; 1/11 - Dinner; 1/15 - All meals; 1/16 - Dinner; 1/17 - Lunch & Dinner; 1/18 - all day. 1/21. 22, 28,29 - Breakfast & Lunch. February 2009 No documentation of meal intake for the following dates: 2/11, 2/12, 2/18, 2/19, 2/24, 2/25 - Breakfast and Lunch March 2009 No documentation of meal intake for the following dates: 3/18, 3/20 - All meals; 3/19 - Dinner. There was no documented evidence on the meal intake form or in the progress notes that Resident had difficulty chewing as documented by the Dietician on 1/22/09, during the meal observation. On 9/9/09 at 9:20 am, the Dietary Manager (DM) indicated she followed Resident #23 on the Weight Committee. The Weight Committee usually meets once a week on Wednesdays. The Weight Committee reviews the residents weight, evaluates the current therapy and makes recommendations for changes if indicated. The DM added that during February 2009, the Weight Committee did not meet. Therefore, Resident #23 was not followed and evaluated during that period. The DM also acknowledged that weekly weights should have continued on Resident #23 due to the weight loss. The DM also confirmed the	F 325		

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F 325	Continued From page 86 documentation of Resident #23's Dietary intake should have been more accurate.	F 325		
F 371 SS=L	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 21794 Based on observation, policy review, and interview, the facility failed to ensure food was stored, prepared, and distributed under sanitary conditions. Findings include: On 9/01/09, beginning at 8:00 AM a tour of the facility's kitchen was conducted by a Nevada State Health Inspector (Sanitarian). She observed several immediate concerns in the areas of temperature control, food protection, food equipment and utensils, poisonous and toxic materials, food protection, piping, and floors, walls and ceilings surfaces. The State Health Inspector notified the survey team of the concerns and a surveyor confirmed with the State Health Inspector the following findings: 1. Interview with and document review from the	F 371		

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F 371	Continued From page 87 State Health Inspector revealed that two large pans of cooked pork roast prepared on 8/31/09, were at 65 degrees in the walk-in refrigerator. Note: The temperature control of the pork roast, a potentially hazardous food, must be cooled rapidly from 140 degrees to 70 degrees within 2 hours and 70 degrees to 40 degrees within 4 hours. The pork was discarded as a precaution the morning of 09/01/09. 2. Observation of the walk-in refrigerator revealed a temperature of 44 degrees and contained cottage cheese and various other potentially hazardous food. 3. Interview with and document review from the State Health Inspector revealed the walk-in refrigerator also contained three separate thermometers, and each thermometer recorded a separate temperature ranging from 40 degrees to 55 degrees. 4. Interview with and document review from the State Health Inspector revealed a steam table hot holding food ready for service to the residents, contained both scrambled eggs and boiled eggs with temperatures well below 140 degrees. The temperature of the scrambled eggs were 118 degrees and the boiled eggs measured at 129 degrees. The food products were discarded the morning of 09/01/09. 5. Observation of the dish machine which was tested and revealed no measurable amount of sanitizer was being dispensed during a sanitizing cycle. Note: The requirement is for a concentration of 50 ppm (parts per million) of chlorine.	F 371		

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6. Observation of a large hole in the ceiling located over the kitchen's food preparation sink and ware washing area revealed the piping for the facility's automatic fire sprinkler system was leaking water onto the prep sink and three compartment sinks.

Because the dish machine did not function properly (4. above) and because the three compartment sink was contaminated (5. above), the facility did not have means to clean and sanitize dishes.

7. The above leak was observed to be splashing onto a rack that contained clean kitchenware. The rack was contaminated from the water leakage and pieces of soaked ceiling tiles lay on the racks.

8. The floor was observed soiled from the water leakage and numerous pieces of ceiling sections (gypsum board) scattered on the floor in the areas of preparation and the 3 compartment sink.

9. The floor in general in the dietary department were observed to be dirty.

10. Interview with and document review from the State Health Inspector revealed scoop handles were observed to be left in food thickener.

11. Interview with and document review from the State Health Inspector revealed an unlabeled container of cleaning liquid (potential poisonous or toxic item) was located in the janitor's closet.

12. The walk-in freezer door was observed to not be able to close properly and revealed large ice build-up at the door and just inside the door on

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F 371	Continued From page 89 the plastic curtain (apparatus to assist in maintaining cold temperatures in the walk-in). Interview with the State Health Inspector revealed that she had notified the facility at approximately 9:30 AM of the significant food service/sanitation violations. She also indicated through her investigation that the Dietary Manager was ServSafe trained, however the Dietary Manager was still having dietary staff move forward with meal service without making the necessary adjustments to the food service/sanitation violations. Due to that conduct, the State Health Inspector had suspended the "Food Establishment Permit" for the dietary department at approximately 10:00 AM. Subsequently, due to the food service/sanitation violations, the facility's failure to make the necessary adjustments relative to those violations, and the suspension of the state Food Establishment Permit, an immediate jeopardy was identified and an immediate plan of action to remedy the potential for harm was requested. Once notified of immediate jeopardy, the facility made efforts to provide for the lunch meal and make the necessary correction in the dietary department. The facility did not get an acceptable plan of correction for remediating the immediate jeopardy to the State Agency until approximately 2:00 PM. Surveyor: 13109 The Administrator indicated that the lunch meal was typically served at noon. At approximately 11:00 AM, the facility indicated that they were going to order fast food (pizza, fried chicken, hamburgers) for the residents. When the Director	F 371		

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of Nursing and the Administrator were interviewed on how they were going to feed those individuals with special diets or those requiring mechanical or puree foods, they told the survey team that they would have to get back with that information. Approximately 30-minutes later the facility's response was to have their neighbor, a licensed healthcare facility, provide those meals. The Director of Nursing was then interview as to how many residents would require special diets or required mechanical or puree foods, they did not know and deferred to the Dietician, who was located at another facility across town. Approximately 11:45 AM the facility provided a list of those residents with special dietary needs and was in the process of notifying their Physicians to see which residents would be eligible for a "special diet holiday".

The facility had Staff that typically did not assist with the meal service available to help distribute the ordered fast food, at that time the Administrator was interviewed as to how the non dietary and nursing staff assisting in distributing the fast food would know to not serve those residents the that still required special dietary needs. The Administrator left and came back in a couple of minutes after speaking with the Dietary Manager, and indicated that the facility would identify those individuals with special dietary needs with their existing identifying card and pedestal system (use on food trays) and place them in front of the residents and would inform all assisting staff of the system.

The Dietician arrived around noon and meal service began approximately 12:05 PM for residents without dietary restrictions. Evaluation of the means of food preparation, temperature

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F 371	Continued From page 91 logging, and transporting of the food to the facility from the neighboring facility was conducted with both facilities' Dietary Staff. The facility's Dietary staff (two employees) were going to use the neighboring facility's transport equipment, unenclosed cart. After some discussion, the facility Dietary Staff agreed to use the enclosed cart and would cleaning it prior to use and would ensure food containers would be covered while in transit. The neighboring facility Dietary Manager agrees to record temperatures, because the facility Dietary Staff did not have thermometers. The menu was sausage and sauerkraut for the special diets, which was questionable given the high salt content for these food products. Note: The food served was the same as what the neighboring and assisting facility's residents received, basically what was available at the time. The surveyor returned to the facility ahead of the food at 12:30 PM, and the meal service for the residents with special dietary restrictions was initiated approximately 12:40 PM. A re-inspection between 4:00 and 5:00 PM on 9/1/09, by the State Health Inspector determined that the Food Establishment Permit suspension could be lifted and re-instated due to the corrections made by the facility. These corrections were confirmed by the State Agency Surveyors. Related by the State Health Inspector, the facility indicated that the evening meal would consist of fruit plates, cottage cheese plates, and sandwiches.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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F 428	Continued From page 92 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Surveyor: 26907 Based on record review and interview, the facility failed to ensure recommendations by the pharmacist review were addressed in a timely manner for 2 of 32 residents. (#1, # 6) Findings include: Resident #1 Resident #1 was a 55 year old male admitted to the facility on 12/15/08, with diagnoses including Traumatic Subdural Hematoma, Psychosis, and Lumbosacral Spondylosis. The Pharmacist Progress Notes/Medication Regimen Review dated 8/19/09 indicated, "Resident currently receives Depakote 1000 mg (milligrams) twice daily, Risperdal 1 mg twice daily, and Trazodone 100 mg q HS (every night) that has been on board since admit on 12/08. He is noted to get good sleep and is due for a trial reduction. Recommend a trial decrease of Trazodone to 50 mg q HS." The Medication Administration Record (MAR) dated September 2009, revealed Resident #1 continued to receive Trazodone 100 mg through	F 428		

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MISSION PINES NURSING & REHABILITATION CTR	2860 E. CHEYENNE AVENUE NORTH LAS VEGAS, NV 89030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 93 9/1/09. On 9/2/09, the Director of Nurses indicated the recommendations of the pharmacist were given to the DON. The DON then forwarded the recommendations to the Unit Manager to follow up with the physician. On 9/2/09 in the afternoon, the Unit Manager revealed the pharmacist recommendations for Resident # 1 had been faxed to the physician on 8/31/09 and there was no response to date. On 9/2/09, the Unit Manager called the attending physician and received orders to reduce Trazodone to 50 mg HS, as recommended by the pharmacist. Resident #6 Resident #6 was a 44 year old female admitted to the facility on 6/27/08 with diagnoses including Mental Retardation, Hypertension, Diabetes and Depression. The Pharmacist Progress Notes/Medication Regimen Review dated 8/19/09 indicated, " Resident is receiving Glucotrol XL (extended release) 5 mg (milligrams) q (every) AM for DM (Diabetes Mellitus). Her FSBS (fasting blood sugar) in the AM continues to be > 200 (greater than 200) ...with SSI (Sliding Scale Insulin) utilized. In order to bring blood glucose down a bit, recommend increasing Glucotrol XL to 10 mg daily. " The resident's Medication Administration Record (MAR) dated September 2009, revealed Resident #6 received Glucotrol XL 5 mg daily through	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29E037	A. BUILDING _____ B. WING _____	09/10/2009

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F 428	Continued From page 94 9/2/09. On 9/2/09, the Director of Nurses indicated the recommendations of the pharmacist are given to the DON. The DON then forwards the recommendations to the Unit Manager to follow up with the physician. On 9/2/09 in the afternoon, the Unit Manager revealed the pharmacist recommendations for Resident # 6 had been faxed to the physician on 8/31/09 and there was no response to date. On 9/2/09, in the afternoon, the Unit Manager called the attending physician and received the order to increase Resident #6's Glucotrol to 10 mg daily effective 9/3/09.	F 428		